IMPACT OF SUBSTANCE ABUSE ON STATE AND LOCAL CHILD WELFARE SYSTEMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

APRIL 30, 1991

Serial 102-18

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
43-583 WASHINGTON : 1991

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-035313-0

H781-45

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, Jr., Indiana
HAROLD E. FORD, Tennessee
ED JENKINS, Georgia
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, Jr., Arkansas
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington

BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
BILL THOMAS, California
RAYMOND J. McGRATH, New York
ROD CHANDLER, Washington
E. CLAY SHAW, Jr., Florida
DON SUNDQUIST, Tennessee
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
FRED GRANDY, Iowa

Robert J. Leonard, *Chief Counsel and Staff Director*
Phillip D. Moseley, *Minority Chief of Staff*

Subcommittee on Human Resources

HAROLD E. FORD, Tennessee, *Chairman*

THOMAS J. DOWNEY, New York, *Acting Chairman*
BARBARA B. KENNELLY, Connecticut
MICHAEL A. ANDREWS, Texas
JIM McDERMOTT, Washington
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

E. CLAY SHAW, Jr., Florida
NANCY L. JOHNSON, Connecticut
FRED GRANDY, Iowa
ROD CHANDLER, Washington

CONTENTS

Page

Press releases of Thursday, March 14, and Wednesday, April 3, 1991, announcing the hearing 2

WITNESSES

American Bar Association, Judith Larsen 43
Child Welfare League of American, Inc., Richard L. Jones 79
Gray, Hon. Ernestine S., Orleans Parish Juvenile Court, New Orleans, La 39
Los Angeles County Department of Children's Services, Carlos M. Sosa 18
National Association of Children's Hospitals and Related Institutions, Inc., Alice Kitchen 61
National Black Child Development Institute, Inc., Clarice D. Walker 69
National Council on Alcoholism and Drug Dependence, Inc., Christine Lubinski 88
New York City Human Resources Administration, Barbara J. Sabol 8

SUBMISSIONS FOR THE RECORD

Brant, Mary Patricia, Broward General Medical Center, Ft. Lauderdale, Fla., letter 110
Golden, Arlene J., Broward General Medical Center, letter 112
March, Esther, M.D., Broward General Medical Center, letter 115
Udell, Brian D., M.D., Broward General Medical Center, letter 116

IMPACT OF SUBSTANCE ABUSE ON STATE AND LOCAL CHILD WELFARE SYSTEMS

TUESDAY, APRIL 30, 1991

House of Representatives,
Committee on Ways and Means,
Subcommittee on Human Resources,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room B-318, Rayburn House Office Building, Hon. Thomas J. Downey (acting chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 14, 1991

PRESS RELEASE #8
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE (202) 225-1721

THE HONORABLE THOMAS J. DOWNEY (D., N.Y.), ACTING CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE IMPACT OF SUBSTANCE ABUSE ON STATE AND LOCAL CHILD WELFARE SYSTEMS

The Honorable Thomas J. Downey (D., N.Y.), Acting Chairman, Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, today announced the Subcommittee has scheduled the second in a series of hearings on the Federally-supported child welfare programs under the jurisdiction of the Committee. The hearing, which will address the impact of substance abuse on State and local child welfare systems, will be held on Thursday, April 18, 1991, at 10:00 a.m. in room B-318 Rayburn House Office Building.

BACKGROUND

Substance abuse, both drug and alcohol, has long been a significant factor in all three components of State and local child welfare services, including child protective, foster care and adoption services, and there is strong evidence suggesting that the recent upsurge in the use of cocaine has placed additional strains on these service systems.

Between 1986 and 1988, New York City experienced a three-fold increase in the number of child abuse and neglect cases where parents were involved with drugs. The number of drug-exposed infants referred to the child welfare system in Los Angeles increased by 342 percent between 1986 and 1989, and in Chicago by 1,735 percent.

Many experts and practitioners associate the increase in the foster care caseload between 1986 and 1989 with the crack epidemic, since the caseload increase appears to have been concentrated in those areas hardest hit by this drug, such as California and New York. In New York, the foster care caseload increased 64 percent between 1984 and 1988. California experienced a caseload increase of 65 percent between 1985 and 1989. There is some evidence, however, that these trends are changing. Child protection caseloads have recently declined in New York City, and the foster care caseload appears to be leveling.

SCOPE OF THE HEARING

This hearing will investigate the major issues that arise for a child welfare system as it seeks to address substance abuse problems among families. The Subcommittee expects that each witness will focus on one of the following sets of questions:

(1) To what extent is substance abuse a characteristic of the child welfare caseloads in the States? How does the abuse of alcohol compare to the abuse of illicit drugs?

(2) Substance abuse is only one of many serious problems facing families in the Nation's child welfare systems. To what extent should families with substance abuse problems be treated differently from other families in the system?

(3) Federal law requires that States provide child welfare services to families in order to prevent the unnecessary removal of a child from the home, or in order to allow a child who has been removed to return home. To what extent are drug and alcohol treatment included among the services that States make available? How available is treatment for women? What do we know about the success of alternative treatment programs for various subclasses of substances?

(4) Many child welfare legal issues have surfaced along with the crack epidemic. To what extent should substance abuse be treated as a special issue in State laws which address child abuse and neglect? and the termination of parental rights?

(MORE)

(5) What are some examples of innovative programs at the State or local level which are working to address substance abuse problems among the child welfare population?

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

The Subcommittee will hear testimony from public witnesses. Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler or Diane Kirkland [(202) 225-1721] no later than noon, Thursday, April 11, 1991. The telephone request must be followed by a formal written request to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee [(202) 225-1025].

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. **(See formatting requirements below.)** This process will afford more time for Members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question witnesses, all witnesses scheduled to appear are required to submit 200 copies of their prepared statements to the Subcommittee office, B-317 Rayburn House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons wishing to submit written statements for the printed record of the hearing should submit at least six (6) copies of their statements by close of business, Thursday, May 2, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public, they may deliver 100 additional copies for this purpose to the Subcommittee office, room B-317 Rayburn House Office Building, on or before the day of the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

* * * CHANGE IN DATE * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, APRIL 3, 1991

PRESS RELEASE #8-REVISED
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1025

THE HONORABLE THOMAS J. DOWNEY (D., N.Y.), ACTING CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A NEW DATE FOR THE HEARING ON THE IMPACT OF SUBSTANCE ABUSE ON STATE AND LOCAL CHILD WELFARE SYSTEMS

The Honorable Thomas J. Downey (D., N.Y.), Acting Chairman, Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the impact of substance abuse on State and local child welfare systems has been rescheduled for Tuesday, April 30, 1991, beginning at 10:00 a.m. in room B-318 Rayburn House Office Building.

Please see press release #8, dated March 14, 1991, for additional details regarding the hearing.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

The Subcommittee will hear testimony from public witnesses. Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler or Diane Kirkland [(202) 225-1721] no later than noon, Tuesday, April 23, 1991. The telephone request must be followed by a formal written request to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee [(202) 225-1025].

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing.

(MORE)

(See formatting requirements below.) This process will afford more time for Members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question witnesses, all witnesses scheduled to appear are required to submit 200 copies of their prepared statements to the Subcommittee office, B-317 Rayburn House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons wishing to submit written statements for the printed record of the hearing should submit at least six (6) copies of their statements by close of business, Tuesday, May 14, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public, they may deliver 100 additional copies for this purpose to the Subcommittee office, room B-317 Rayburn House Office Building, on or before the day of the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Acting Chairman DOWNEY. The subcommittee will come to order.

Last year, this subcommittee visited the intensive care nurseries at two Washington, D.C. hospitals. For me, it was both a sad and a sobering experience. What I saw were dedicated doctors, nurses and social workers, working against seemingly insurmountable odds to help children whose only light of hope is being snuffed out by substance abuse.

But this is only part of the problem. The fact is that many American families are under attack from an enemy from within, drug and alcohol abuse. It is an enemy that attacks the very foundation of American families and threatens to short-circuit an already overloaded child welfare system.

Whether it is medical care for infants born exposed to drugs, drug treatment programs for the parents, or child care for older siblings while parents undergo treatment, many child welfare agencies find themselves overwhelmed by the scope of services needed to preserve families in crisis due to substance abuse. Yet, if these families fail, the cost to the children, the parents, and to society can be even higher.

Today, we will be hearing from a number of distinguished witnesses representing public agencies, the courts, and private organizations, who work on a daily basis with the problems of families in crisis due to substance abuse. I would like to thank these witnesses for traveling to share with us their experiences.

Ms. Barbara Sabol, commissioner of the New York City Human Resources Administration, and Mr. Carlos Sosa, deputy director of the L.A. County Department of Children's Services, will brief us first on how substance abuse affects the caseloads and operations of the Nation's largest child welfare agencies.

Before they come to the witness table, I would like to recognize my friend, the distinguished ranking member of the subcommittee, Clay Shaw.

Clay.

Mr. SHAW. Thank you, Mr. Chairman.

I have a formal statement that I would ask to be incorporated in the record.

Mr. Chairman, I want to compliment you for having held these hearings. As you mentioned in your opening statement, last year you and I, with other members of the committee, went to some of the local hospitals and looked at the end result of drug abuse—the birth of deformed children.

This is an increasing problem that we are seeing all across the United States. We are seeing now mothers that are having their third, now perhaps even fourth cocaine addicted baby, and this is bringing about a living monument to the awful effect that drug abuse is having on this society.

This living monument will live with these children for the rest of their lives, or what lives they might have. They will be physically and mentally impaired, they will be disruptive, they will be a problem for the school systems of this country, they will be a tremendous problem to their families and to the people who will have to live with them and live around them. They will require constant care, they will become an extraordinary drain upon future taxpayers, and, of course, the most disheartening thing is that they will never have any chance to be productive human beings who are in charge of their own destiny.

I can think of no legislation that this committee or this Congress could work on that would be more important than trying to solve the problems of drug addiction for the unborn. I would hope, Mr. Chairman, that this is something, knowing of your commitment and your knowing of my commitment, we can actually do something about. My commitment started years ago when I saw a baby die in Broward General Hospital while I was in the neonatal unit. A cocaine addicted baby died right there while I was standing over the incubator. This is a problem that has such deep roots that it goes far beyond the jurisdiction of this committee, and, parenthetically, and really having nothing to do with this hearing, I think it is very important that our Government should start concentrating more efforts in the coca fields in Peru, Bolivia, and Colombia.

I would hope that we keep the price tag down to one where we can work with the administration. We should not measure our accomplishments or what we are about to do or our commitment in terms of dollars; we should try to get maximum efficiency out of our programs and work hard to get something that is going to work.

This is truly doing something for babies who have absolutely no ability to do anything for themselves, and I think it is quite a proper function of the Federal Government and something that we should take an extraordinary amount of time to look into in great depth.

Again, I compliment you for these hearings.

[The opening statement follows:]

OPENING STATEMENT OF HON. E. CLAY SHAW, JR.

Mr. Chairman, I thank you for holding this important series of hearings on the Federal-State child welfare system. Drug use by parents, the topic of today's hearings, is a particularly important part of the child welfare problem. Our members should be able to learn a great deal from today's witnesses about the scope of the drug problem and potential solutions.

I want to draw the subcommittee's attention to the difficulty of passing child welfare legislation this year. The subcommittee is often the high-water mark for social legislation: Bills that come out of our subcommittee tend to be reduced at full committee, on the House floor, or in House-Senate conferences. I can understand that some Members want to show their commitment to addressing the Nation's social problems, but perhaps passing big but impractical bills out of subcommittee is not the best possible approach.

Especially this year. Members are just now coming to realize the impact of last year's budget agreement on proposals for new spending. It is slowly becoming clear that there aren't many pots of money lying around to finance new spending, and that further tax increases seem unlikely. The new budget rule we must follow is simple enough: No pay, no go.

Several of us on the Republican side are seriously committed to passing a child welfare bill this year. Mrs. Johnson has been especially active in this regard. We think it unwise to spend time with a $5 billion bill. Rather, we strongly recommend that our subcommittee work with the administration, make maximum use of the dramatic expenditure increases that are already in the child welfare baseline under title IV-E, and try to form a package that contains perhaps $1 billion or so in new spending over the next 5 years. Most important, we want to start talking as soon as possible about a financing mechanism for whatever amount of new money we decide to spend.

Worthy intentions are good; actual accomplishments are even better.

Acting Chairman DOWNEY. Thank you, Clay.

The committee will now hear from two distinguished witnesses who are the front-line soldiers in this battle, Commissioner Barbara Sabol and Deputy Director Carlos Sosa.

Commissioner Sabol.

STATEMENT OF BARBARA J. SABOL, ADMINISTRATOR/COMMISSIONER, NEW YORK CITY HUMAN RESOURCES ADMINISTRATION

Ms. SABOL. Thank you, Mr. Chairman.

Good morning to you, Mr. Chairman and members of the committee. I am Barbara Sabol, administrator/commissioner of the Human Resources Administration of the city of New York. As you know, we are the largest human services delivery system in the country, and the children we serve, the children of the poor, are most at risk.

Homelessness, AIDS, joblessness, and the onslaught of crack, all symptoms of society's larger problems, have taken from far too many children their fundamental rights to a strong family by which to be nurtured, and a strong community in which to live.

Nationwide foster care placements have increased nearly 30 percent since 1986, from 280,000 to 360,000. In New York City, the foster care population has risen almost 2½ times between 1986 and 1990. There are now more than 45,000 children in care.

A large part of the increase is related to substance abuse. Drug exposed infants constitute a large part of abuse and neglect reports in many cities. In 1984, only one-fifth of New York City's foster care admissions were children under the age of 2. By 1988, that age group accounted for 1 in every 3 admissions.

I appeared before Congress more than a decade ago to talk about child welfare and child welfare reform, and there are major differences between then and now. The three major differences are: An increase in the caseload, how the children come to us, and who they are.

Not only is our caseload vastly different from that of 1979, when you wrote the Adoption Assistance and Child Welfare Act, under which we now operate, but the way in which children and families come into our care is also vastly different.

Today, 80 percent of our placements are emergency placements. In the past, a majority of the placements were voluntary. In 1983, for example, only 30 percent of placements were because of child abuse and neglect. In 1988—and I think this is an important fact—4,643 babies were reported to our child welfare system because of positive toxicologies. That was a 30-percent increase from the previous year, and a 268-percent increase from 1986.

We in child welfare have struggled to meet these increasing demands, despite not being able to ameliorate the real sources of poverty. Social service programs are limited in what they can achieve, but we cannot take too lightly the accomplishments.

Successful social service programs provide families with social support networks, and they deliver services in a comprehensive and coordinated way.

The most successful have a strong base in the communities where the families and children at risk live.

The administration of Mayor Dinkins is committed to developing policies and programs designed to buttress vulnerable families so that they can stay together and thrive.

The programs we design and implement are guided by the principle that prevention, in the long run, is better and cheaper than cure. We have been expanding what I call front-end prevention programs, like Head Start and day care, our comprehensive case management program for pregnant and parenting teens, and our employment and training programs for AFDC mothers. These programs will help prevent serious health and social problems and save tax dollars now and in the years to come.

We believe that the child welfare system should be better attuned to children's needs, and that children should be helped in the context of families, whenever possible.

Because our first priority must always be to keep families together and children safe, we are working to enhance family resources and capabilities, both to prevent foster care placement, where possible, and to minimize its impact and duration, when placement is unavoidable. To the extent feasible, we believe that foster care should be used as a way to strengthen families, not to replace them.

Because of the minimal number of Federal dollars for child welfare services, many of our key preventive initiatives are funded with only State and city dollars, which at this point in time are a diminishing resource. Some are even worried that it will be a vanishing resource.

One of our key preventive initiatives, the family rehabilitation program, is aimed at the problem of substance abuse. It provides intensive case management and drug treatment to families where substance abuse is a central problem. We have designed this program to allow mothers with substance abuse problems to obtain treatment, while remaining with their children.

Over 1,100 families have been served by the program to date, and while long-term outcome data from the program, which just began in 1989, is not yet available, the initial indications are very promising.

Another key program, again funded with State and city dollars, that we are working very hard to expand is our preventive housing subsidy program, which provides financial assistance in cases where a lack of housing prevents the discharge of children from care.

We have also strongly supported a State legislative measure to provide similar subsidies to families with children at risk of foster care placement.

Our goal is to provide a wide range of services to families and children in the communities where they live. We believe that community-based services will not only lead to better outcomes for our families and children, but will also create a process that will stabilize and empower our communities.

I commend you, Mr. Chairman, on the important leadership you have provided on child welfare reform. Your Family Preservation Act of 1991 will, by substantially increasing funding for the title IV-B child welfare services program, provide a critically important step in the right direction. While title IV-B was intended to fund the kind of programs and services designed to preserve and restore families, the Federal resources have been scarce.

While we fully support virtually all the provisions in last year's bill and look forward to its reintroduction, we strongly object to the bill's provision reducing the time that States have to submit IV-E claims from 2 years to 1 year. Many States, especially those with locally administered programs, would have great difficulty meeting this deadline, and untimely filing could potentially result in substantial amounts of denied reimbursement. AFDC, Medicaid, and other entitlement programs have a 2-year claiming period. The same timeframe, I believe, should apply to IV-E.

A decade has passed since the Congress last set out to reform the child welfare system. The problems facing children and families have changed dramatically over the years, and, as a result, the nature and role of the child welfare system has also undergone profound change. It is critical that the system be adapted to reflect the new demands that these changes have created.

We recommend that the overly rigid title IV-E administrative mandates be made relevant to the children and families that we serve today. Also, an equitable and rational approach to evaluate performance, including the imposition of fiscal penalties, must be established. That is not something we often talk about. Let me explain and discuss further some of our concerns.

First of all, too often, the Federal rules that govern child welfare programs are left over from the days when foster care and AFDC were together in the same title of the Social Security Act. In the AFDC program, our responsibility to serve the applicant rests solely on the applicant's ability to prove financial need in a timely fashion.

In the foster care program, on the other hand, our primary responsibility is to promote the best interests of the child. The time deadlines that often concern us deal with insuring the safety of the child. If a child needs emergency protective care we are going to act quickly. We will deal with trying to locate the mother and get her to talk about her resources when the child is secure.

Because IV-E requirements often mirror the AFDC requirements, in that they concentrate on how fast we get the parent to verify income, they often result in foster care reimbursement for vulnerable children being denied.

Technical problems, such as the rules governing the emergency removal of a child from the home, is a major issue. It poses a problem in qualifying—and I underline qualifying here—children for IV-E eligibility. The rules governing emergency removal of children must be reexamined.

The Department of Health and Human Services has determined that children who are not removed from the home of an eligible relative or physically removed from the home 6 months prior to entering foster care are ineligible for title IV-E reimbursement.

Let me give you a typical case: A child whose mother, for perhaps substance abuse reasons, has been erratic. The child has been left with a neighbor or relative. Eventually, it is clear to that caretaker, after 8 months, that the mother is not returning. The child now comes in to the foster care system, but cannot be claimed under IV-E, because the requirement that children come into care within 6 months of their removal from the parent's home has been violated. The child's needs have not changed, but the rule has been violated.

This is particularly problematic in the case of relative foster care, where it is not uncommon for a child to be living together with a relatively and a parent. If the parent leaves, again, as often as not, for reasons related to substance abuse, we believe that the best foster care parent for the child would be the relative, but the child is not federally eligible for IV-E, unless we take the child out of the home, at least temporarily. This disruption could take a week, it could take a month, it is bad for the child and it could clog the system. The needs of the child have not changed. Their eligibility is denied because we have violated a rule.

Clearly, Congress did not intend that a literal reading of the statute relating to removal of the child override its intent to protect the child and to expand, not limit Federal participation in the foster care program.

In New York, as well as in some of our sister States, we have also found that audit reviews conducted by HHS are narrowly focused on technical compliance. They essentially ignore the provision of services. These audits are typically conducted years after the period under review, and require the original placement record, which may involve retrieving records 10 or 15 years old. There is no tolerance for missing records.

There is also no mechanism for distinguishing between the significance of a given error. Let me give you an example. The failure to obtain a Social Security number results in the same level of disallowance as a substantive error, such as lack of legal authority.

Clearly, these audits have no constructive value and are only means to be punitive. AFDC title IV-A has a quality control system; title IV-E does not. When HHS applies some of the IV-A requirements to IV-E, it means concentrating on the speed of income verification and such other rules, not the needs of the child and how they are being met.

What is needed is a quality control system that reflects the unique issues of the foster care system and the provision of services, and which offers States and localities criteria by which they may be fairly judged.

Before concluding, I would like to stress that we are looking forward to the outcome of your deliberations, culminating, I hope, in the reintroduction of your bill, Mr. Chairman. During the intervening weeks, we hope to have the opportunity to work with the subcommittee, both on the ideas to refine eligibility and to establish a quality control system.

We also urge the committee to consider making cities eligible directly for demonstration projects, enabling us to test efforts in pre- and post-placement services. While it is the State that has the final direct fiscal link with the Federal Government, Congress has already recognized the unique needs of cities in the case of AIDS, through the Ryan White Act, and homeless, through the McKinney Act. The crisis in foster care is equally critical.

You have asked us to comment on the impact of substance abuse on children and foster care. It is debilitating, it is devastating, it is demoralizing, but it is not hopeless. There are some things we know that work. We are doing some of them. We have some suggestions that we think will fix or change the system. I have suggested several of those today.

Let me end by saying we are deeply grateful for your interest and the interest of this committee and your commitment to improving services for children in a time that is vastly different from when the legislation was passed. We look forward to continuing to work with you.

Thank you.

[The prepared statement follows:]

STATEMENT OF BARBARA J. SABOL, ADMINISTRATOR/COMMISSIONER CITY OF NEW YORK HUMAN RESOURCES ADMINISTRATION

INTRODUCTION

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM BARBARA J. SABOL, ADMINISTRATOR/COMMISSIONER OF THE HUMAN RESOURCES ADMINISTRATION OF THE CITY OF NEW YORK. THANK YOU FOR THE OPPORTUNITY TO SPEAK AT TODAY'S HEARING ON THE IMPACT OF SUBSTANCE ABUSE ON STATE AND LOCAL CHILD WELFARE SYSTEMS. I AM EAGER TO SHARE SOME OF MY IDEAS, EXPERIENCES AND PLANS FOR MEETING THE URGENT NEEDS OF CHILDREN AND FAMILIES.

THE HUMAN RESOURCES ADMINISTRATION IS THE LARGEST HUMAN SERVICES DELIVERY SYSTEM IN THE COUNTRY. WE PROVIDE BASIC INCOME SUPPORTS AND MEDICAL CARE TO 570,000 CHILDREN LIVING IN FAMILIES ON PUBLIC ASSISTANCE. ON ANY NIGHT OF THE YEAR WE SHELTER OVER 6,000 CHILDREN. OUR CHILD DAY CARE PROGRAMS SERVICE OVER 44,000 CHILDREN. OVER 10 PERCENT OF ALL CHILDREN IN FOSTER CARE IN THE UNITED STATES -- 45,000 -- ARE IN MY CARE AND CUSTODY.

THE CHILDREN OF THE POOR ARE THE CHILDREN MOST AT RISK. HOMELESSNESS, SUBSTANCE ABUSE, CRIME, NEGLECT AND ABUSE, AND AIDS ARE ALL RELATED TO THE POVERTY IN WHICH CHILDREN LIVE. I CAN PAINT A PICTURE FOR YOU OF A CHILD, AND THE DEVASTATION HE OR SHE FACES, WITH A PARADE OF STATISTICS. WHILE THE FOLLOWING FACTS HARDLY DRAW A COMPREHENSIVE PORTRAIT, THEY EFFECTIVELY SKETCH AN INTOLERABLE REALITY. WHILE MOST OF MY EXAMPLES ARE ABOUT NEW YORK CITY, WHERE THE PROBLEMS ARE SEEMINGLY OVERWHELMING, THEY WILL HELP SHOW THE DYNAMICS UNFOLDING IN ALL OUR MAJOR CITIES.

- SOME 100,000 CHILDREN IN THE UNITED STATES DO NOT HAVE A PLACE TO LIVE EACH NIGHT. THE FAMILIES IN NEW YORK CITY'S SHELTER SYSTEM (WHO MAKE UP MORE THAN HALF OF SHELTER RESIDENTS) INCLUDE 1,383 CHILDREN UNDER TWO YEARS, 3,205 UNDER SIX YEARS, AND 6,094 UNDER THE AGE OF SIXTEEN. THESE FIGURES DO NOT INCLUDE THE COUNTLESS HOMELESS YOUTH WHO LIVE ON THE CITY'S STREETS. MOREOVER, NEARLY HALF OF WHAT SOME HAVE ESTIMATED TO BE 100,000 FAMILIES IN NEW YORK CURRENTLY SHARING AN APARTMENT WITH ANOTHER FAMILY -- DOUBLED UP -- AND AT RISK OF BECOMING HOMELESS.

- IT HAS BEEN ESTIMATED THAT 10 TO 20 PERCENT OF NEWBORN INFANTS IN LOW INCOME URBAN AREAS AROUND THE COUNTRY ARE EXPOSED TO DRUGS BEFORE THEY ARE BORN. IN NEW YORK CITY, IN 1989, THERE WERE OVER 7,000 ABUSE AND NEGLECT REPORTS IN WHICH SUBSTANCE ABUSE BY PARENTS WAS A FACTOR.

- TODAY, THERE ARE AN ESTIMATED 360,000 CHILDREN IN FOSTER CARE IN THE UNITED STATES, THE MAJORITY DUE TO ABUSE AND NEGLECT. NATIONWIDE, THE NUMBER OF CHILD ABUSE AND NEGLECT REPORTS INCREASED 200 PERCENT IN THE LAST DECADE. IN NEW YORK CITY ALONE, THE NUMBER OF REPORTS DOUBLED BETWEEN 1982 AND 1989.

- AS OF LAST FEBRUARY, 583 CASES OF PEDIATRIC AIDS HAD BEEN REPORTED IN NEW YORK CITY, AND 240 OF THESE CHILDREN HAVE DIED.

- IN NEW YORK CITY, IN 1988, OVER 700 CHILDREN AND YOUNG PEOPLE UNDER 24 YEARS OF AGE WERE VICTIMS OF HOMICIDE. MORE THAN ONE CHILD UNDER THE AGE OF FOUR WAS MURDERED EVERY TWO WEEKS, A TOTAL OF 26 CHILDREN DURING THE YEAR.

THESE GRIM STATISTICS HELP TO PORTRAY THE REALITY OF TOO MANY OF

THE URBAN POOR. MANY DIFFERENT FACTORS CONTRIBUTE TO THIS INCREASE IN POVERTY.

INCREASES IN POVERTY ARE MOST ALARMING AMONG FAMILIES HEADED BY SINGLE WOMEN. WHILE ONE IN FIVE CHILDREN IN THE UNITED STATES IS POOR, ALMOST ONE IN TWO CHILDREN LIVING IN FEMALE HEADED HOUSEHOLDS LIVES BELOW THE POVERTY LEVEL. IN FACT, FEMALE-HEADED HOUSEHOLDS ARE ALMOST SIX TIMES MORE LIKELY TO BE POOR THAN FAMILIES HEADED BY MARRIED COUPLES. IN NEW YORK CITY, THREE FOURTHS OF CHILDREN UNDER THE AGE OF SIX LIVING IN FEMALE-HEADED HOUSEHOLDS ARE POOR.

WHILE BOTH PUBLIC AND PRIVATE SOCIAL SERVICE AGENCIES CAN ATTEMPT TO AMELIORATE THE CONDITIONS OF POOR CHILDREN AND FAMILIES, OUR INTERVENTIONS ARE, BY THEIR VERY NATURE, LIMITED. THEY DO NOT, AND CANNOT, TO ANY LARGE EXTENT, ADDRESS THE CAUSES OF POVERTY.

CHILD WELFARE TRENDS

HOMELESSNESS, AIDS, JOBLESSNESS, AND THE ONSLAUGHT OF CRACK -- ALL SYMPTOMS OF SOCIETY'S LARGER PROBLEMS -- HAVE TAKEN FROM TOO MANY CHILDREN THEIR FUNDAMENTAL RIGHT TO A STRONG FAMILY TO BE NURTURED BY AND A STRONG COMMUNITY IN WHICH TO LIVE.

AN ESTIMATED 2.2 MILLION CHILDREN NATIONWIDE WERE REPORTED ABUSED OR NEGLECTED IN 1987. MOST OF THESE REPORTS INVOLVED CHILDREN FROM POOR FAMILIES. THAT IS NOT TO SAY THAT MIDDLE AND HIGHER INCOME FAMILIES DO NOT MALTREAT THEIR CHILDREN; UNDERREPORTING DOES INDEED OCCUR. HOWEVER, MANY OF THE RISKS ASSOCIATED WITH LIVING IN POVERTY HAVE BEEN CORRELATED WITH HIGHER RATES OF ABUSE AND NEGLECT.

A STUDY OF FOSTER CHILDREN IN FIVE MAJOR U.S. CITIES (INCLUDING NEW YORK) PUBLISHED IN 1989 BY THE NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE FOUND THAT 54 PERCENT WERE PLACED BECAUSE OF NEGLECT AND 38 PERCENT FOR ABUSE. PARENTAL SUBSTANCE ABUSE WAS REPORTED IN 36 PERCENT OF PLACEMENTS, AND POVERTY IN 25 PERCENT. IN ADDITION, INADEQUATE HOUSING WAS CITED IN 30 PERCENT OF CASES, AND HOMELESSNESS IN 11 PERCENT. AFDC WAS THE PRIMARY SOURCE OF INCOME FOR 65 PERCENT OF THE FAMILIES BEFORE PLACEMENT. THE TYPICAL HEAD OF THE FAMILY WAS A SINGLE MOTHER.

NATIONWIDE, FOSTER CARE PLACEMENTS HAVE INCREASED NEARLY 30 PERCENT SINCE 1986 -- FROM 280,000 TO 360,000. IN NEW YORK CITY, THE FOSTER CARE POPULATION HAS RISEN ALMOST TWO AND ONE HALF TIMES BETWEEN 1986 AND 1990.

THE 1980'S NOT ONLY SAW A SHARP RISE IN THE NUMBER OF CHILDREN IN CARE, BUT HAS ALSO WITNESSED A SHIFT IN THE COMPOSITION OF THE FOSTER CARE CASELOAD AND THE EMERGENCE OF A NEW MODE OF CARE.

ACROSS THE COUNTRY, THE NUMBER OF YOUNG CHILDREN IN FOSTER CARE HAS INCREASED, IN LARGE PART BECAUSE OF MATERNAL SUBSTANCE ABUSE. DRUG-EXPOSED INFANTS CONSTITUTE A LARGE PART OF ABUSE AND NEGLECT REPORTS IN MANY CITIES. IN NEW YORK CITY, FOR EXAMPLE, IN 1988, 4,643 BABIES WERE REPORTED TO OUR CHILD WELFARE ADMINISTRATION BECAUSE OF A POSITIVE TOXICOLOGY FOR DRUGS -- 30 PERCENT MORE THAN A YEAR PREVIOUSLY AND 268 PERCENT MORE THAN IN 1986, WHEN WE FIRST BEGAN TRACKING THIS INFORMATION. IN 1984, ONLY ONE-FIFTH OF NEW YORK CITY'S FOSTER CARE ADMISSIONS WERE CHILDREN UNDER TWO YEARS OF AGE. BY 1988, THAT AGE GROUP ACCOUNTED FOR ONE IN EVERY THREE ADMISSIONS.

I'D LIKE TO NOTE THAT WE SHOULD BE CAREFUL NOT TO PREMATURELY LABEL THESE CHILDREN. THE DRUG-EXPOSED INFANTS WE HEAR SO MUCH ABOUT ARE NOT "A LOST GENERATION." THEY ARE NOT "CHILDREN OF THE DAMNED." THEY ARE NOT "IMPAIRED KIDS ... [WHO] THREATEN TO CRIPPLE THE CITY," AS THE HEADLINES IN THE TABLOIDS CLAIM. WE MUST REFRAIN FROM ATTACHING A STIGMA TO THESE CHILDREN THAT WILL

FOLLOW THEM THROUGHOUT THEIR LIVES. WE MUST NOT JUMP TO RASH CONCLUSIONS ABOUT THEIR FATE. WE MUST LEARN MORE ABOUT THEIR NEEDS SO THAT WE CAN PLAN OUR INTERVENTIONS ACCORDINGLY.

THE DECADE OF THE 80'S ALSO SAW AN INCREASE IN THE USE OF RELATIVES AS FOSTER CARE PROVIDERS. PROMPTED BY A LAWSUIT, IN 1986 THE STATE OF NEW YORK ISSUED A DIRECTIVE REQUIRING FOSTER CARE PAYMENTS TO EXTENDED FAMILY MEMBERS WHO TAKE IN THEIR YOUNG RELATIVES AS FOSTER CHILDREN. FROM A POPULATION OF ABOUT 1,000 CHILDREN IN 1986, TODAY, NEW YORK CITY'S KINSHIP FOSTER CARE PROGRAM SERVES 20,000 CHILDREN AND ACCOUNTS FOR ALMOST HALF OF THE CITY'S FOSTER CARE CASELOAD. OUR WORKERS NOW SEEK PLACEMENT WITH RELATIVES AS THE PREFERRED RESPONSE WHEN PLACEMENT IS NECESSARY. WE BELIEVE PLACEMENT WITH RELATIVES, WHICH OFFERS GREATER CONTINUITY AND FAMILIARITY TO THE CHILD, HAS IMPORTANT ADVANTAGES OVER PLACEMENT IN REGULAR FOSTER CARE.

WHAT A CHILD WELFARE SYSTEM CAN ACCOMPLISH

AS I HAVE ALREADY INDICATED, NOT BEING ABLE TO AMELIORATE THE REAL SOURCES OF POVERTY, SOCIAL SERVICE PROGRAMS ARE LIMITED IN WHAT THEY CAN ACCOMPLISH. BUT WE MUST NOT TAKE TOO LIGHTLY THESE ACCOMPLISHMENTS. SUCCESSFUL SOCIAL SERVICE PROGRAMS PROVIDE FAMILIES WITH SOCIAL SUPPORT NETWORKS, AND THEY DELIVER SERVICES IN A COMPREHENSIVE AND COORDINATED APPROACH. THE MOST SUCCESSFUL HAVE A STRONG BASE IN THE COMMUNITIES WHERE THE FAMILIES WITH CHILDREN AT RISK LIVE.

WE MUST CHANGE THE WAY WE THINK ABOUT SERVICES. CURRENTLY, PROGRAMS AND THE MECHANISMS TO DELIVER SERVICES ARE OFTEN DEVELOPED IN RESPONSE TO AN IMMEDIATE OR ONGOING PROBLEM THAT HAS REACHED CRISIS PROPORTIONS. INTERVENTIONS ARE INTENDED TO REMEDY A PARTICULAR RISK FACTOR FACING A SPECIFIC CLIENT GROUP, SUCH AS CHILDREN AT RISK OF OUT-OF-HOME PLACEMENT. THIS APPROACH TO SERVICE DELIVERY PERPETUATES AN OPERATIONAL PRACTICE THAT DEALS ONLY WITH IMMEDIATE PROBLEMS AND CRISES, INSTEAD OF LOOKING TO LONG RANGE PLANNING TO PREVENT THE RECURRENCE OF THESE CRISES IN THE FUTURE. TYPICALLY, WHEN THERE HAS BEEN A SIGNIFICANT INCREASE IN THE NUMBER OF CHILDREN ENTERING FOSTER CARE, THE RESPONSE HAS BEEN TO EXPAND THE SUPPLY OF BEDS AVAILABLE TO MEET THE DEMAND.

OUR ADMINISTRATION -- MAYOR DINKINS' ADMINISTRATION -- IS COMMITTED TO DEVELOPING POLICIES AND PROGRAMS DESIGNED TO BUTTRESS VULNERABLE FAMILIES SO THAT THEY CAN STAY TOGETHER AND HOPEFULLY THRIVE. THE PROGRAMS WE DESIGN AND IMPLEMENT ARE GUIDED BY THE PRINCIPLE THAT PREVENTION, IN THE LONG RUN, IS BETTER AND CHEAPER THAN CURE.

WE HAVE BEEN EXPANDING WHAT I CALL "FRONT END PREVENTION" PROGRAMS LIKE HEAD START AND DAY CARE, OUR COMPREHENSIVE CASE MANAGEMENT PROGRAM FOR PREGNANT AND PARENTING TEENS AND EMPLOYMENT AND TRAINING PROGRAMS FOR AFDC MOTHERS. THESE PROGRAMS WILL HELP PREVENT SERIOUS HEALTH AND SOCIAL PROBLEMS AND SAVE TAXPAYER DOLLARS IN THE YEARS TO COME.

WE BELIEVE THAT THE CHILD WELFARE SYSTEM SHOULD BE ATTUNED TO CHILDREN'S NEEDS AND THAT CHILDREN SHOULD BE HELPED IN THE CONTEXT OF FAMILIES WHENEVER POSSIBLE. BECAUSE OUR FIRST PRIORITY MUST ALWAYS BE TO KEEP FAMILIES TOGETHER, WE ARE WORKING TO ENHANCE FAMILY RESOURCES AND CAPABILITIES, BOTH TO PREVENT FOSTER CARE PLACEMENT WHERE POSSIBLE, AND TO MINIMIZE ITS IMPACT AND DURATION WHEN PLACEMENT IS UNAVOIDABLE. TO THE EXTENT FEASIBLE, WE BELIEVE THAT FOSTER CARE SHOULD BE USED AS A WAY TO STRENGTHEN FAMILIES, NOT TO REPLACE THEM.

OUR GOAL IS TO SUPPORT FAMILIES AT RISK OF PLACEMENT WITH PREVENTIVE SERVICES TO ALLOW THEM TO PROVIDE FULLY FOR THEIR CHILDREN. WHEN PLACEMENT IS UNAVOIDABLE, HOWEVER, OUR PRIORITY

IS TO PLACE CHILDREN WITH OTHER RELATIVES, TO ENSURE THAT SIBLINGS IN CARE ARE KEPT TOGETHER, AND TO WORK WITH FAMILIES TO SPEED UP REUNIFICATION. WE ARE MOVING AGGRESSIVELY TO SHAPE OUR PROGRAMS TO MEET THESE GOALS.

ONE OF OUR KEY PREVENTIVE INITIATIVES, THE FAMILY REHABILITATION PROGRAM, IS AIMED AT THE PROBLEM OF SUBSTANCE ABUSE. IT PROVIDES INTENSIVE CASE MANAGEMENT AND DRUG TREATMENT TO FAMILIES WHERE SUBSTANCE ABUSE IS A CENTRAL PROBLEM. WE HAVE DESIGNED THIS PROGRAM TO ALLOW MOTHERS WITH SUBSTANCE ABUSE PROBLEMS TO OBTAIN TREATMENT WHILE REMAINING WITH THEIR CHILDREN. OVER 1,100 FAMILIES HAVE BEEN SERVED BY THE PROGRAM TO DATE. WHILE LONG-TERM OUTCOME DATA FROM THE PROGRAM, WHICH BEGAN IN 1989, IS NOT YET AVAILABLE, INITIAL INDICATIONS ARE VERY PROMISING.

WE ARE ALSO WORKING HARD TO EXPAND THE UTILIZATION OF OUR PREVENTIVE HOUSING SUBSIDY PROGRAM WHICH PROVIDES FINANCIAL ASSISTANCE IN CASES WHERE A LACK OF HOUSING PREVENTS THE DISCHARGE OF CHILDREN FROM CARE. WE HAVE ALSO STRONGLY SUPPORTED A STATE LEGISLATIVE MEASURE TO PROVIDE SIMILAR SUBSIDIES TO FAMILIES WITH CHILDREN AT RISK OF PLACEMENT. ALTHOUGH THIS BILL WAS VETOED BY THE GOVERNOR LAST YEAR, WE HOPE THAT IT WILL RECEIVE FAVORABLE CONSIDERATION THIS YEAR. WE BELIEVE THAT PROVIDING A PREVENTIVE SERVICES HOUSING SUBSIDY TO FAMILIES WHOSE CHILDREN ARE IN IMMINENT DANGER OF PLACEMENT SOLELY BECAUSE OF A LACK OF HOUSING IS NOT ONLY HUMANE, BUT IS ALSO COST-EFFECTIVE IN THE LONG RUN.

OUR GOAL IS TO PROVIDE A WIDE RANGE OF SERVICES TO FAMILIES AND CHILDREN WITHIN THE COMMUNITIES WHERE THEY LIVE. WE BELIEVE THAT COMMUNITY-BASED SERVICE DELIVERY WILL NOT ONLY LEAD TO BETTER OUTCOMES FOR OUR FAMILIES AND CHILDREN, BUT ALSO CREATE A PROCESS THAT WILL STABILIZE AND EMPOWER OUR COMMUNITIES. IN OUR FOSTER CARE SYSTEM, FOR EXAMPLE, THE MOST SUCCESSFUL AGENCIES RESPONSIBLE FOR PLACING AND CARING FOR OUR CHILDREN ARE THE ONES WITH STRONG ROOTS IN THE COMMUNITY IN WHICH THEY ARE BASED. THESE AGENCIES HAVE A RESERVE OF TRAINED AND CARING FAMILIES WITHIN THE COMMUNITY WITH WHOM CHILDREN CAN BE PLACED. THUS, THE CHILDREN WHO MUST BE REMOVED FROM THEIR FAMILIES AND HOMES ARE STILL ABLE TO REMAIN IN THEIR COMMUNITIES.

LEGISLATIVE PROPOSALS

I COMMEND YOU, MR. CHAIRMAN, ON THE IMPORTANT LEADERSHIP YOU HAVE PROVIDED ON CHILD WELFARE REFORM. LAST YEAR'S FAMILY PRESERVATION ACT OF 1990 (H.R. 5020), WHICH SUBSTANTIALLY INCREASED FUNDING FOR THE TITLE IV-B CHILD WELFARE SERVICES PROGRAM, WAS AN IMPORTANT STEP IN THE RIGHT DIRECTION. WHILE TITLE IV-B WAS INTENDED TO FUND THE KINDS OF PROGRAMS AND SERVICES DESIGNED TO PRESERVE AND RESTORE FAMILIES, THE FEDERAL RESOURCES HAVE BEEN SCARCE. INDEED, THE GAP BETWEEN THE NEED FOR SERVICES AND THE RESOURCES AVAILABLE HAS BEEN EVER WIDENING.

WE ALSO SUPPORT THE PROVISION IN THE BILL REQUIRING STATES TO PROVIDE AFTERCARE SERVICE TO STRENGTHEN FAMILIES WHOSE CHILDREN HAVE RETURNED HOME FOLLOWING A FOSTER CARE PLACEMENT. IT IS CRUCIAL THAT FAMILIES BE PROVIDED THE NECESSARY SUPPORTS TO PREVENT A CHILD'S REENTRY INTO FOSTER CARE. LIKEWISE, ADOPTIVE FAMILIES SHOULD ALSO BE PROVIDED POST-ADOPTION SERVICES TO PREVENT DISRUPTED ADOPTIONS. FEDERAL FUNDING FOR THESE SERVICES MUST BE MADE AVAILABLE.

WHILE WE FULLY SUPPORT VIRTUALLY ALL OF THE PROVISIONS IN LAST YEAR'S BILL AND LOOK FORWARD TO ITS REINTRODUCTION, WE STRONGLY OBJECT TO THE BILL'S PROVISION REDUCING THE TIME STATES HAVE TO SUBMIT IV-E CLAIMS FROM TWO YEARS TO ONE YEAR. MANY STATES, ESPECIALLY THOSE WITH LOCALLY ADMINISTERED PROGRAMS, WOULD HAVE GREAT DIFFICULTY MEETING THIS DEADLINE, AND UNTIMELY FILING COULD POTENTIALLY RESULT IN SUBSTANTIAL AMOUNTS OF DENIED REIMBURSEMENT. AFDC, MEDICAID AND OTHER ENTITLEMENT PROGRAMS

HAVE A TWO YEAR CLAIMING PERIOD; THE SAME TIMEFRAME SHOULD APPLY TO TITLE IV-E.

A DECADE HAS PASSED SINCE THE CONGRESS LAST SET OUT TO REFORM THE CHILD WELFARE SYSTEM. THE PROBLEMS FACING CHILDREN AND FAMILIES HAVE CHANGED DRAMATICALLY OVER THE YEARS. AND, AS A RESULT, THE NATURE AND ROLE OF THE CHILD WELFARE SYSTEM HAS UNDERGONE PROFOUND CHANGE. IT IS CRITICAL THAT THE SYSTEM BE ADAPTED TO REFLECT THE NEW DEMANDS THAT THESE CHANGES HAVE CREATED.

IN ADDITION, TITLE IV-E FOSTER CARE PROGRAMMATIC AND FISCAL REVIEW REQUIREMENTS MANDATED BY PUBLIC LAW 96-272 MUST BE REVISED TO BETTER REFLECT THE CURRENT PRESSURES ON THE CHILD WELFARE SYSTEM. FOSTER CARE IS A SERVICE PROGRAM, NOT AN INCOME TRANSFER PROGRAM. UNLIKE PUBLIC ASSISTANCE PROGRAMS WHICH PROVIDE SERVICE ONLY TO THOSE FINANCIALLY ELIGIBLE, FOSTER CARE IS AN EMERGENCY SERVICE THAT MUST BE AVAILABLE TO ANY CHILD IN NEED, REGARDLESS OF FINANCIAL CONSIDERATIONS. UNLIKE PUBLIC ASSISTANCE WHERE THE CLIENT MUST SUBMIT DOCUMENTATION TO PROVE ELIGIBILITY AS A CONDITION OF RECEIVING ASSISTANCE, THERE IS NO INCENTIVE FOR PARENTS TO COOPERATE IN ESTABLISHING TITLE IV-E ELIGIBILITY. DOCUMENTING FINANCIAL RESOURCES IS NOT A HIGH PRIORITY FOR A PARENT WHEN THEIR CHILD IS BEING TAKEN FROM THEM. ACCORDINGLY, ELIGIBILITY AND COMPLIANCE STANDARDS SHOULD BE REFORMED TO REFLECT THE INTENT OF THE PROGRAM -- TO PROVIDE CARE FOR THE MOST VULNERABLE MEMBERS OF OUR SOCIETY.

WE RECOMMEND THAT THE OVERLY RIGID TITLE IV-E ELIGIBILITY CRITERIA BE EASED, AND THAT AN EQUITABLE AND RATIONALE MECHANISM TO EVALUATE PERFORMANCE, INCLUDING THE IMPOSITION OF FISCAL PENALTIES, BE ESTABLISHED. LET ME TALK ABOUT SOME OF OUR CONCERNS.

IN NEW YORK, WE HAVE OFTEN FOUND THAT OVERLY RIGID ELIGIBILITY STANDARDS RESULT IN FOSTER CARE REIMBURSEMENT FOR VULNERABLE CHILDREN BEING DENIED. TAKE, FOR EXAMPLE, THE RULES GOVERNING THE EMERGENCY REMOVAL OF A CHILD FROM THE HOME. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) HAS DETERMINED THAT CHILDREN WHO ARE NOT REMOVED FROM THE HOME OF AN ELIGIBLE RELATIVE OR PHYSICALLY REMOVED FROM THE HOME SIX MONTHS PRIOR TO ENTERING FOSTER CARE ARE INELIGIBLE FOR TITLE IV-E REIMBURSEMENT. FOR INSTANCE, A CHILD WHO HAS BEEN LEFT WITH A NEIGHBOR FOR EIGHT MONTHS AND THEN COMES INTO FOSTER CARE CANNOT BE CLAIMED UNDER IV-E. THIS NARROW INTERPRETATION IS PARTICULARLY PROBLEMATIC IN THE CASE OF RELATIVE FOSTER CARE, WHERE CHILDREN MAY BE LIVING WITH A RELATIVE MORE THAN SIX MONTHS PRIOR TO THAT RELATIVE'S CERTIFICATION AS A FOSTER PARENT.

ANOTHER EXAMPLE RELATES TO THE SOURCE OF INCOME OF THE PARENTS. AS I NOTED, HHS TYPICALLY APPLIES THE KIND OF DOCUMENTATION REQUIREMENTS AND BURDENS OF PROOF ASSOCIATED WITH AFDC AND OTHER ENTITLEMENT PROGRAMS. FOR EXAMPLE, AUDITORS HAVE ROUTINELY FOUND INELIGIBLE FOR AFDC, AND THUS IV-E, CASES WHERE PARENTS HAVE INCOME FROM ILLEGAL ACTIVITIES, UNLESS THE CASE RECORD CLEARLY DOCUMENTS THAT THE INCOME EARNED IS BELOW THE AFDC STANDARD. THIS SUGGESTS THAT THE CASEWORKER SHOULD SOMEHOW FIGURE OUT HOW TO FORCE A PARENT (WHOSE CHILD HAS JUST BEEN TAKEN AWAY FROM HER) TO IDENTIFY AND DOCUMENT EARNINGS FROM PROSTITUTION OR THE SALE OF NARCOTICS.

CLEARLY, CONGRESS DID NOT INTEND THAT A LITERAL READING OF THE STATUTE OVERRIDE ITS VERY INTENT, WHICH WAS TO PROTECT THE CHILD, AND TO EXPAND, NOT LIMIT, FEDERAL PARTICIPATION IN THE FOSTER CARE PROGRAM.

IN NEW YORK, AS WELL AS IN SOME OF OUR SISTER STATES, WE HAVE ALSO FOUND THAT AUDIT REVIEWS CONDUCTED BY HHS ARE NARROWLY FOCUSED ON TECHNICAL COMPLIANCE. THEY ESSENTIALLY IGNORE THE PROVISION OF SERVICES. THESE AUDITS ARE TYPICALLY CONDUCTED

YEARS AFTER THE PERIOD UNDER REVIEW AND REQUIRE THE ORIGINAL PLACEMENT RECORD, WHICH MAY INVOLVE RETRIEVING RECORDS 10 OR 15 YEARS OLD; THERE IS NO TOLERANCE FOR MISSING RECORDS. THERE IS ALSO NO MECHANISM FOR DISTINGUISHING THE SIGNIFICANCE OF A GIVEN "ERROR." FOR EXAMPLE, FAILURE TO OBTAIN A SOCIAL SECURITY NUMBER RESULTS IN THE SAME LEVEL OF DISALLOWANCE AS A SUBSTANTIVE ERROR SUCH AS LACK OF LEGAL AUTHORITY. CLEARLY, THESE AUDITS HAVE NO CONSTRUCTIVE VALUE AND ARE ONLY MEANT TO BE PUNITIVE.

WHAT IS NEEDED IS A QUALITY CONTROL SYSTEM THAT REFLECTS THE UNIQUE ISSUES OF FOSTER CARE SERVICE PROVISION, AND WHICH OFFERS STATES AND LOCALITIES CRITERIA AGAINST WHICH THEY MAY BE FAIRLY JUDGED. SUCH A SYSTEM SHOULD CONTAIN A SYSTEMWIDE TOLERANCE LEVEL BASED ON THE COMBINED PERFORMANCE OF ALL STATES (AS IT IS FOR AFDC); WEIGHING OF ERRORS BASED ON THE SEVERITY OR DEGREE OF NON-COMPLIANCE; MANAGEMENT REVIEWS BY HHS TO HELP STATES IDENTIFY AND CORRECT DEFICIENCIES; AND ALLOCATION OF SANCTION DOLLARS TO IMPROVE SERVICES TO CHILDREN, INCLUDING THE TRAINING OF CHILD WELFARE WORKERS.

CONCLUSION

BEFORE CONCLUDING, I'D LIKE TO STRESS THAT WE ARE LOOKING FORWARD TO THE OUTCOME OF YOUR DELIBERATIONS, CULMINATING IN THE RE-INTRODUCTION OF YOUR BILL, MR. CHAIRMAN. DURING THE INTERVENING WEEKS, WE HOPE TO HAVE THE OPPORTUNITY TO WORK WITH THE SUBCOMMITTEE, BOTH ON OUR IDEAS TO REFINE ELIGIBILITY AND TO ESTABLISH A QUALITY CONTROL SYSTEM.

WE ALSO URGE THE COMMITTEE TO CONSIDER MAKING CITIES ELIGIBLE DIRECTLY FOR DEMONSTRATION PROJECTS, ENABLING US TO TEST EFFORTS IN PRE- AND POST-PLACEMENT SERVICES. WHILE IT IS THE STATES THAT HAVE THE DIRECT FISCAL LINK WITH THE FEDERAL GOVERNMENT, CONGRESS HAS ALSO RECOGNIZED THE UNIQUE NEEDS OF CITIES IN THE CASE OF AIDS, THROUGH THE RYAN WHITE ACT, AND HOMELESSNESS, THROUGH THE MCKINNEY ACT. THE CRISIS IN FOSTER CARE IS EQUALLY AS CRITICAL.

THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY.

Acting Chairman DOWNEY. Thank you, Barbara.

Mr. Sosa.

STATEMENT OF CARLOS M. SOSA, DEPUTY DIRECTOR, LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES

Mr. SOSA. Mr. Chairman and members of the committee, I appreciate the opportunity to be here with you today, to add my voice to the growing chorus of concern about the devastating impact that drugs and alcohol are having on the child welfare system and on the children and families that we serve.

In fact, as everyone in the child welfare field will tell you, the war against drug abuse has become a war against child abuse. My colleague from new York has certainly laid out for you a very good picture of what the problems look like in the provision of service to children who are substance exposed.

As you will hear today, the war against substance exposure of children is not going to be an easy task. It is no easy task in Los Angeles County, either. My department services 50,000 children and their families at any point in time. It is no easy task, given that the majority of these cases, roughly 80 percent, by our estimates, involve some type of substance abuse by the family or the children being born substance exposed, and each year we get more than 2,300 referrals of drug exposed babies. That is more than the total foster care population of the District of Columbia.

It is no easy task, given the scarcity of affordable and accessible prenatal care, drug treatment and other critical support services for families and the children. Drug and alcohol abuse and child abuse are powerful partners. It is rare that a child's membership in a chemically dependent family would spare them from either direct abuse, witnessing violence, participating in criminal activity or a neglectful environment.

In calendar year 1990, our emergency response system in Los Angeles County took into custody 2,347 drug exposed infants. This averages 196 per month, and it represents a 1,678 percent increase over the 1981 figures.

In some States, to give you an idea of how the scope of the problem may be bigger than the figures that the two of us are quoting here, in some States, a positive toxicology test for infants is not a mandatory reporting reason, so what we may have out there is a whole group of children that are never going to come into the system.

Unfortunately, it does not look like it is going to get much easier. This is especially disturbing, considering that the County of Los Angeles is already struggling with a $23 million cut in child welfare services this fiscal year, and a State budget deficit for the next fiscal year of over $13 billion.

In spite of the doom and gloom, our county is currently involved in several innovative efforts. These efforts we have undertaken in the last few years in order to make our services dollars stressed. We have concentrated on three areas.

In the assessment of the services to these children, when a report of drug exposed infant is received, we use an assessment guide developed in conjunction with other agencies and health care professionals to better plot the course of services for the child.

Interagency collaboration, we have moved forward with a variety of projects. For example, our UCLA joint project called TEAMS, which is an acronym for Training, Education and Management Skills, in which children's social workers and public health nurses work together to train others to better care for drug exposed infants and their families, and more can still be done in this area. We have expanded that to providing this kind of education and support, not just to the natural parents or foster parents, but also the relatives of these children.

When Barbara speaks about relatives being involved in the family, roughly 48 percent of all our substance exposed infants in out-of-home care are being cared for by relatives. Nevertheless, there are some other fiscal constraints that allow us to provide broader services to relatives.

We have also established high-risk units, whose sole purpose is to provide intensive services to high-risk drug-exposed infants and their families, with the goal of keeping the families intact during the provision of services. Despite some of these successes, these programs are available only to a small percentage of families who could benefit, due to a shortage of dollars.

We are pleased with several recent legislative victories in the State and Federal level. On the Federal front, we are pleased with last year's focus on substance abuse in the committee's bill H.R. 5020, and that Senator Bentsen followed your lead by including substance abusing family provisions in his bill. We hope to see similar provisions in this year's House bill and recognition that title IV–B child welfare services should be converted to an entitlement program, with increased funding.

I am especially pleased with Congress' passage of Public Law 101-266, which will provide funding for emergency protective services for children whose parents are substance abusers. The key to this is that county-administered child welfare services like California permits local jurisdictions to apply directly for the funds. However, this program is authorized at $40 million, but received slightly less than half of that this fiscal year.

We urge you to do what you can to insure that this program is fully funded.

In closing—and you have my testimony already on record here—when you hear the rest of the testimony today, I want you to remember and put it in this context: It is rare in child welfare where we have an opportunity to provide some early intervention to children, and in this case, when we are dealing with substance exposed infants, we have a window of opportunity in which to bring an array of support services, health, maternal health, and protective services, instead of waiting until they become school-age and then have to deal with an education and a delinquency problem. This is a rare opportunity, and I hope that we get the resources to operate in that context.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF CARLOS M. SOSA, M.S.W., DEPUTY DIRECTOR COUNTY OF LOS ANGELES, DEPARTMENT OF CHILDREN'S SERVICES

INTRODUCTION

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE. I APPRECIATE THE OPPORTUNITY TO BE HERE TODAY TO ADD MY VOICE TO THE GROWING CHORUS OF CONCERN ABOUT THE DEVASTATING IMPACT DRUGS AND ALCOHOL ARE HAVING ON THE CHILD WELFARE SYSTEM AND ON THE CHILDREN AND FAMILIES WE SERVE.

IN FACT, AS ANYONE IN THE CHILD WELFARE FIELD WILL TELL YOU, THE WAR AGAINST DRUG ABUSE HAS BECOME A WAR AGAINST CHILD ABUSE.

BEFORE I BEGIN, I WOULD LIKE TO THANK YOU FOR YOUR EFFORTS TO DO WHAT SOMETIMES SEEMS IMPOSSIBLE: HELP THE CHILD WELFARE SYSTEM FULFILL ITS MISSION OF KEEPING CHILDREN SAFE FROM ABUSE.

AS YOU KNOW, THIS IS NO EASY TASK.

DCS MISSION MADE MORE DIFFICULT BY TRENDS IN CHILD ABUSE, CUTS IN CHILD WELFARE FUNDING

IT IS NO EASY TASK IN LOS ANGELES COUNTY, EITHER, WHERE THE DEPARTMENT OF CHILDREN'S SERVICES (DCS) RECEIVED OVER 108,000 REFERRALS OF ABUSE AND NEGLECT LAST YEAR AND WHERE IT SERVES ABOUT 50,000 CHILDREN AND THEIR FAMILIES AT ANY ONE TIME.

IT IS NO EASY TASK GIVEN THAT THE MAJORITY OF THESE CASES -- ROUGHLY 80% -- INVOLVE SUBSTANCE ABUSE; AND EACH YEAR, WE GET MORE THAN 2,300 REFERRALS OF DRUG-EXPOSED BABIES -- THAT'S MORE THAN THE TOTAL FOSTER CARE POPULATION OF D.C.

AND, IT IS NO EASY TASK GIVEN THE DEARTH OF AFFORDABLE AND ACCESSIBLE PRENATAL CARE, DRUG TREATMENT, AND OTHER CRITICAL SUPPORT SERVICES FOR FAMILIES.

DRUG/ALCOHOL ABUSE AND CHILD ABUSE ARE POWERFUL PARTNERS. IT IS RARE THAT A CHILD'S MEMBERSHIP IN A CHEMICALLY DEPENDENT FAMILY WOULD SPARE THEM FROM EITHER DIRECT ABUSE, WITNESSING VIOLENCE, PARTICIPATING IN CRIMINAL ACTIVITY, OR A NEGLECTFUL ENVIRONMENT.

DCS REFERRALS INVOLVING PRENATAL SUBSTANCE ABUSE HAVE INCREASED DRAMATICALLY. THE STATISTICAL DATA FROM OUR DEPARTMENT DEMONSTRATES THIS PATTERN. IN 1981, JUST AFTER P.L. 96-272 WAS ENACTED, THERE WERE 132 DRUG-EXPOSED INFANT CASES REFERRED TO DCS FOR THE ENTIRE YEAR. IN CALENDAR YEAR 1990, OUR EMERGENCY RESPONSE (INTAKE) REASONS FOR SERVICE FOR DRUG-EXPOSED INFANTS TOTALLED 2,347. THIS AVERAGES 196 PER MONTH AND IS A 1,678% INCREASE OVER THE 1981 FIGURES!

UNFORTUNATELY, IT DOES NOT LOOK LIKE IT'S GOING TO GET MUCH EASIER: IN OUR COUNTY, NEARLY 32,000 CHILDREN WERE IN FOSTER CARE IN 1990, A 70% INCREASE SINCE 1985; COSTS FOR THEIR CARE SKYROCKETED TO $254 MILLION, A 90% JUMP IN THOSE FIVE YEARS.

THIS IS ESPECIALLY DISTURBING CONSIDERING THE COUNTY IS ALREADY STRUGGLING WITH A $23 MILLION CUT IN CHILD WELFARE SERVICES THIS YEAR (OR $55 MILLION FOR CALIFORNIA STATEWIDE); AND A STATE BUDGET DEFICIT OF OVER $13 BILLION.

IN SPITE OF THE DOOM AND GLOOM, OUR COUNTY IS CURRENTLY INVOLVED IN SEVERAL INNOVATIVE EFFORTS, WHICH I WOULD LIKE TO SHARE WITH YOU.

WHAT DCS IS DOING

ASSESSMENT: WHEN A REPORT OF A DRUG-EXPOSED INFANT IS MADE, DCS ASSESSES THESE CASES TO DETERMINE THE LEVEL OF ENDANGERMENT TO THE CHILDREN USING AN ASSESSMENT GUIDE DEVELOPED IN CONJUNCTION WITH OTHER AGENICES AND HEALTH CARE PROFESSIONALS.

INTERAGENCY COLLABORATION: DCS WORKS CLOSELY WITH OTHER AGENCIES TO DEVELOP AND PARTICIPATE IN EFFORTS TO INCREASE AWARENESS AND SERVICES FOR DRUG-EXPOSED BABIES, ABUSED CHILDREN AND THEIR FAMILIES. FOR EXAMPLE, OUR UCLA TEAMS (Training, Education and Management Skills) PROJECT, IN WHICH CHILDREN'S SOCIAL WORKERS AND PUBLIC HEALTH NURSES WORK TOGETHER TO TRAIN OTHERS TO BETTER CARE FOR DRUG-EXPOSED INFANTS AND THEIR FAMILIES. STILL, MORE COULD BE DONE IN THIS AREA.

HIGH RISK UNITS: DCS ALSO OPERATES "HIGH RISK UNITS" IN 3 OF ITS 6 REGIONS. THESE UNITS PROVIDE INTENSIVE SERVICES TO HIGH RISK, DRUG-EXPOSED INFANTS AND THEIR FAMILIES WITH THE GOAL OF KEEPING THE FAMILY INTACT DURING THE PROVISION OF SERVICES. THIS DEMONSTRATES A CHILD WELFARE FAMILY PRESERVATION/SUBSTANCE ABUSE SERVICES LINKAGE, THE SUBJECT OF TOMORROW'S HEARING.

KEY ELEMENTS OF THIS PROGRAM INCLUDE: USE OF A SINGLE WORKER FROM INTAKE TO IMPLEMENTATION OF A CASE PLAN TO ENSURE CONTINUITY AND TO BUILD THE TRUST/CONFIDENCE OF THE PARENTS, COURT; DRUG REHABILITATION OF AT LEAST 6 MONTHS FOR THE MOTHER WITH ROUTINE TESTING AND SUPERVISION BY DCS UP TO 1 YEAR; BUILDING A STRONG SUPPORT SYSTEM FOR THE MOTHER; PARENTING CLASSES; REQUIREMENTS THAT THE MOTHER FOLLOW UP WITH ALL NECESSARY MEDICAL ATTENTION FOR INFANT.

DESPITE ITS SUCCESS, THIS PROGRAM IS ONLY AVAILABLE TO A SMALL PERCENTAGE OF THE FAMILIES WHO COULD BENEFIT.

RECENT LEGISLATIVE VICTORIES

WE ARE ALSO PLEASED WITH SEVERAL RECENT LEGISLATIVE VICTORIES AT THE STATE AND FEDERAL LEVEL.

AT THE STATE LEVEL, LEGISLATION ENACTED LAST SESSION (SB 2669)-CALLS FOR A COORDINATED CONTINUUM OF SERVICES FOR SUBSTANCE ABUSING WOMEN AND THEIR CHILDREN, ALTHOUGH NO MONEY WAS APPROPRIATED FOR THIS PURPOSE. THE ONGOING DILEMMA IS THAT A FRAMEWORK HAS BEEN DEVELOPED, BUT RESOURCES ARE NECESSARY TO DEVELOP PROGRAMS.

ON THE FEDERAL FRONT, WE ARE PLEASED WITH LAST YEAR'S FOCUS ON SUBSTANCE ABUSE IN YOUR COMMITTEE'S BILL, H.R. 5020, AND THAT SENATOR BENSTEN FOLLOWED YOUR LEAD BY INCLUDING SUBSTANCE-ABUSING FAMILIES PROVISIONS IN HIS BILL THIS YEAR (S.4); **WE HOPE TO SEE SIMILAR PROVISIONS IN THIS YEAR'S HOUSE BILL AND THE RECOGNITION THAT TITLE IV-B CHILD WELFARE SERVICES SHOULD BE CONVERTED TO AN ENTITLEMENT PROGRAM WITH INCREASED FUNDING.**

WE ARE ALSO ENCOURAGED BY RECENT INCREASES IN DRUG ABUSE PREVENTION AND TREATMENT FUNDING TARGETED AT WOMEN, PARTICULARLY PREGNANT WOMEN AND THEIR INFANTS, OVER THE PAST FEW YEARS; STILL ONLY 1/3 OF ANTI-DRUG MONEY GOES TOWARD PREVENTION, EDUCATION, TREATMENT (REST GOES TO LAW ENFORCEMENT). **WE URGE YOU TO WORK CLOSELY WITH CONGRESSMAN WAXMAN'S COMMITTEE IN PUTTING TOGETHER AN INTEGRATED, CONTINUUM OF CARE FOR SUBSTANCE ABUSING WOMEN AND THEIR CHILDREN.**

WE ARE ESPECIALLY PLEASED WITH CONGRESS' PASSAGE OF P.L. 101-266, WHICH WILL PROVIDE FUNDING FOR EMERGENCY PROTECTIVE SERVICES FOR CHILDREN WHOSE PARENTS ARE SUBSTANCE ABUSERS. A KEY PROVISION FOR STATE SUPERVISED, COUNTY ADMINISTERED CHILD WELFARE SYSTEMS LIKE CALIFORNIA PERMITS LOCAL JURISDICTIONS TO APPLY DIRECTLY FOR THE FUNDS. THIS PROGRAM IS AUTHORIZED AT $40 MILLION, BUT RECEIVED SLIGHTLY LESS THAN HALF OF THAT ($19.5 M) FOR THIS FISCAL YEAR. **WE URGE YOU TO DO WHAT YOU CAN TO ENSURE THAT THIS PROGRAM IS FULLY FUNDED.**

WHILE WE ARE ENCOURAGED BY THESE GAINS, WE NEED TO GO EVEN FURTHER.

WHERE WE GO FROM HERE

IF WE ARE EVER GOING TO RID OUR NURSERIES, OUR FOSTER HOMES AND OUR SPECIAL EDUCATION CLASSES OF DRUG-EXPOSED INFANTS AND YOUTH, WE WILL NEED TO WAKE UP TO THE FACT THAT MANY OF OUR NATION'S WOMEN AND CHILDREN ARE IN SERIOUS TROUBLE.

WE WILL NEED TO WAKE UP TO THE FACT THAT THIS PROBLEM WILL NOT GO AWAY BY RHETORIC ALONE: IT WILL TAKE A SERIOUS MONETARY COMMITMENT TO CHILD PROTECTION AND WELFARE.

AND, WE WILL NEED TO WAKE UP TO THE FACT THAT SUBSTANCE ABUSE IS A PROBLEM THAT AFFECTS US ALL; AND AS SUCH, WILL REQUIRE ALL OF US, WORKING TOGETHER, TO SOLVE IT. FORTUNATELY FOR US AND FOR THE CHILDREN OF THIS NATION. THIS COMMITTEE AND THOSE AT THE HOUSE SUBCOMMITTEES ON HEALTH AND THE ENVIRONMENT OR SELECT EDUCATION HAVE CONTINUED TO BE RESPONSIVE TO THESE ISSUES.

I URGE YOU TO ROUSE YOUR COLLEAGUES ON CAPITOL HILL TO ENACT LEGISLATION THAT WILL:

-- KEEP FAMILIES TOGETHER, NOT APART, WHENEVER POSSIBLE; (FAMILY PRESERVATION)

-- PROVIDE FOR APPROPRIATE AND TIMELY PRENATAL CARE AND TREATMENT OF WOMEN WITH SUBSTANCE ABUSE PROBLEMS (ESPECIALLY RESIDENTIAL PROGRAMS THAT ALLOW CHILDREN TO STAY WITH THEIR MOTHERS DURING TREATMENT);

-- ENCOURAGE THE HEALTH, SUBSTANCE ABUSE, AND SOCIAL SERVICES SYSTEMS TO WORK TOGETHER TO PROVIDE COMPREHENSIVE, INTEGRATED CARE AND PROVIDE INCENTIVES TO ACCOMPLISH THIS;

-- SUPPORT EDUCATION AND TRAINING OF CHILDRENS SOCIAL WORKERS ON THE NATURE OF ADDICTION AND ITS ROLE IN CHILD ABUSE;

-- PROVIDE ADEQUATE TRAINING, RESPITE CARE AND OTHER SUPPORTS FOR FOSTER PARENTS WHO CARE FOR DRUG-AFFECTED CHILDREN, BY PROVIDING THEM WITH ADEQUATE TRAINING, RESPITE CARE AND OTHER SUPPORTS.

IN ADDITION, WE WOULD LIKE TO SEE:

-- GREATER FLEXIBILITY OF COURT LIMITS FOR PERMANENCY PLANNING FOR SUBSTANCE ABUSING FAMILIES; AND

-- FEDERAL REIMBURSEMENT FOR RELATIVE CARETAKERS, WHO ARE INCREASINGLY CALLED UPON TO CARE FOR THESE CHILDREN.

THESE SIMPLE SUGGESTIONS, WE FEEL, CAN HAVE A TREMENDOUS IMPACT ON THE CHILD WELFARE SYSTEM.

AGAIN, I APPRECIATE THE OPPORTUNITY TO TESTIFY THIS MORNING; THE DEPARTMENT OF CHILDREN'S SERVICES STANDS READY TO ASSIST YOU IN MEETING THE MOMENTOUS CHALLENGE BEFORE US.

April 1991

FACT SHEET

LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES

SPECIALIZED SERVICES ON BEHALF OF INFANTS WHO HAVE BEEN PRENATALLY EXPOSED TO DRUGS/ALCOHOL

I. PHILOSOPHY AND PURPOSE OF HIGH RISK UNITS

The responsibility of the Department of Children's Services (DCS) is wide-ranging in regard to situations of abused and neglected children. However, in those offices having High Risk Drug Baby units, the services to this population have been specialized. The High Risk units have developed and tested a standardized set of criteria for decision-making on cases involving drug babies. A single Children's Social Worker remains on the case from the beginning. In cases in which the family unit is assessed to be capable of learning the skills necessary for the care of the unit, and in which the parents are committed to drug rehabilitation, every effort will be made by DCS to allow the infant to remain in the home of the parents under supervision of DCS and with the support of a variety of community service agencies. This arrangement is in the form of a legally binding agreement between the agency and the parents pursuant to California Dependency statutes for a period of 6 to 12 months.

Some of the aspects in the design that were unique (for Los Angeles County) were the following:

1. A single social worker would handle the case from the point of original referral to DCS and would do all necessary tasks associated with the plan (including the Juvenile Court work, if needed) for a period of 6 to 12 months.
2. There would be close coordination and networking between a small number of DCS staff and the local hospitals which would enhance relationships and communication -- often resulting in a more orderly handling of the case.
3. Whenever feasible, efforts would be made to keep the infant with the mother under DCS supervision -- preferably through a voluntary agreement.
4. These units would work closely with the Public Health Nurses, Regional Centers, and specialized medical providers to develop multi-disciplinary assessments of the families and to constantly increase the level of expertise in the staff.

II. RESULTS

Approximately 50% of the drug babies assigned to the Exposition Park office are being discharged back to their mothers under voluntary supervision of DCS, while the mothers undergo at least 6 months of drug rehabilitation.

Preliminary data in one region which typically serves about 400 families per year, shows that 36% of a sample of infants referred for drug exposure to the program between January 1989 and 1990, remained at home under DCS supervision, while the other 64% went to court. Of those cases in which the infant stayed at home, 63% were closed successfully within 12 months. Of those infants whose cases went to court, 12% were placed with their parents, 50% were placed with relatives and the remaining 38% were placed in non-related foster homes. The number of infants remaining at home at intake is now closer to 50%.

With a reduced worker caseload in this project, extensive pre-placement preventive services are being provided to enable mothers and their extended family to learn how to care for these fragile infants while rehabilitating their own lives.

Because of the expertise developed by the workers, the handling of drug baby cases is much more consistent than had previously been the case. If the effort to help the mother make a safe home for the child is unsuccessful, clear guidelines are in place to take the matter before the Juvenile Court, with the same worker who has been attempting to work with the family submitting the recommendations to the court. The efforts at resolution before going to court are very persuasive in showing that court action is used as a last resort for the safety of the baby. Over the past several months, we have seen only about 10% of the cases under voluntary supervision have to go to court. In this context, this project provides "family preservation" services.

III. ACCESS TO SERVICES FROM HIGH RISK UNITS

Referrals to the High Risk units are usually made by hospital personnel through the DCS Child Abuse Hotline (1-800-540-4000) to the office which provides services for the areas in which the family resides.

IV. OTHER AGENCY CONTACTS/NETWORKS

The High Risk units network closely with a wide variety of other community services:

- Regional Center for the Developmentally Disabled Early Intervention Program.
- Los Angeles County Department of Health Services: Hospital personnel, physicians, Public Health Nurses, Children's Ark, etc.
- UCLA TEAMS (Training, Education and Management Skills) Project.
- Drug and Alcohol rehabilitation programs -- in-patient as well as out-patient.
- Counseling and parenting agencies, therapeutic Day Care (e.g. Headstart, etc.).
- 12 Step Groups (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Adult Children of Alcoholics, etc.).
- County Probation/State Department of Corrections.
- Los Angeles Unified School District.
- Foster Parent Associations and Community Colleges.

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN'S SERVICES

CASE NAME ____________________

STATE NUMBER ____________________

ASSESSMENT GUIDE FOR INFANTS PRENATALLY EXPOSED TO DRUGS

List infant(s) being assessed in Part A. Assess Infant(s) for each risk factor and enter name(s) under Low, Intermediate or High Risk in Part B. Write N/A if factor does not apply or Unknown if information is not known. Write analysis of risk in Part C. Assess siblings on standard Assessment Guide.

A. Child(ren) ____________________ ____________________

	B.	FACTOR	LOW RISK	INTERMEDIATE RISK	HIGH RISK
CHILD	1.	Infant's drug withdrawal symptoms			
	2.	Special medical and/ or physical problems			
	3.	Special care needs of child			
CARETAKER	4.	Current drug use			
	5.	Drug treatment history			
	6.	Prenatal care			
	7.	Parent's physical intellectual, or emotional abilities			
	8.	Parent's level of cooperation			
	9.	Parent's awareness of impact of drug use on child			
	10.	Parenting skills and responsiveness to infant			
	11.	History of abuse/ neglect			
ENVIRONMENT (PHYSICAL & SOCIAL)	12.	Father or parent substitute in home Name ______			
	13.	Strength of family support systems			
	14.	Drug use in home			
	15.	Sibling assessment (use standard Risk Assessment Guide for sibs)			
	16.	Environmental condition of home			

C. CSW Analysis (consider risk factors and family strengths)

____

____

____

____

____

CSW ____________________ Date ____________

76A929G DCS 181 (11/88)

ASSESSMENT MATRIX FOR INFANTS PRENATALLY EXPOSED TO DRUGS

FACTOR	(a) LOW RISK	(b) INTERMEDIATE RISK	(c) HIGH RISK
1. Infant's drug withdrawal symptoms	Withdrawal symptoms not apparent	Mild tremors; sleeps @ least 3 hrs. after feeding; feeding well; normal stools	Vomiting; watery stools; fever; sleeps less than 2 hrs. after feeding; marked tremors; poor feeding; high pitched cry; seizures; lethargic; on meds for drug withdrawal
2. Special medical &/or physical problems	No apparent med. or phys. prob.	Minor med. or phys. prob. which do not significantly affect infant's vital life functions or physical & intellectual development	Any pre-term inf. (born at or before 36 wks.) &/or phys. or med. prob. which significantly impact vital life functions or phys. & intel. developm. (e.g., cardiac defect, apnea, visual or hearing handicap, seizure disorder)
3. Special care needs of child	Only routine pediatric care; no special quipment or medication	Monthly pediatric care visits & no medicine or special equipment	Requires 2 or more monthly visits for pediatric care &/or special equipment or medication
4. Current drug use	Not currently using any drugs	Occasional 1-2x wk. or wknd. use	Use more than 2x wk.; any use of PCP or Crack
5. Drug treatment history	Entered drug trtmt. early in pregnancy, remains in program & considered compliant	Entered drug trtmt. early in pregnancy, remains in program, but attendance sporadic &/or continues to use drugs	Not in drug trtmt. program or entered in 3rd trimester
6. Prenatal care	Sought early prenatal care and consistent with follow-up	Sought prenatal care in 2nd trimester but inconsistent w/prenatal follow-up/medical advice	Did not seek prenatal care until 3rd trimester; no prenatal care
7. Parent's physical, intellectual, or emotional abilities	No intellectual/ physical limitations; realistic expectations of child; in full control of mental faculties	Mild physical/emotional handicap; mild intellectual limitations which would not significantly impact ability to care for child	Mod. to severely handicapped; poor perception of reality; unrealistic expectations/ perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/ mental illness; poor impulse control (i.e., demonstrated evidence of violence in home)
8. Parent's level of cooperation	Willingness & ability to work w/agency to resolve problem & protect child	Overtly compliant w/investigator &/or presence in home of non-drug using adult to assure minimal cooperation w/agency & follow thru w/med. recommend.	Doesn't believe there is prob.; refuses to cooperate; disinterested or evasive
9. Parent's awareness of impact of drug use on child	Expresses concern/ interest about drugs' effect on child & sought professional advice & counseling	Displays concern/interest in child but denies symptoms & special needs	Displays lack of concern/ interest for child & denies symptoms
10. Parenting skills & responsiveness to infant	Parent exhibits appropriate parenting skills & knowledge re: special medical follow-up care and is responsive to infant's needs		Parent may prov. appr. phys. care but is unresponsive to infant's needs (i.e., lack of response to crying of infant. Poor eye contact, infrequent visits, inappropriate expectations and criticism of child)
11. History of abuse/ neglect	No known history of abuse/neglect	Prior protective services provided to child or sibs. with that episode resolved & case closed	Pending child abuse/neglect investigation; previous abuse/ neglect of serious nature; prior dependency
12. Father or parent substitute (F or PS) in home. name ______ (Circle F or PS to specify)	F or PS in home, who is a supportive/ stabilizing influence & available to assist w/caretaking	Stable F or PS in home, but assumes only minimal caretaker responsibility for child	F or PS who resides w/family & has poor impulse control (i.e., demonstrated evidence of violence in home), &/or is involved in drug activity
13. Strength of family support systems	Family, neighbors, or friends available & committed to help; membership in church, community, or social group	Family supportive but not in geographic area; some support from friends & neighbors; limited community services available	No relatives or friends available/committed; geographically isolated from community service; no phone; no transportation available
14. Drug use in home	No member of household suspected to be involved in drug activity (sale, use, and/or mfg.)		Any one in the household suspected to be involved in drug activity
15. Sibling assessment (use standard Risk Assessment Guide for sibs.)	Education, medical & environmental needs being met for all sibs	Some but not all educ., med., & environ. needs being met for all sibs.	Few educ., med., & environ. needs being met for all sibs.
16. Environmental condition of home	Home relatively clean w/no apparent safety or health hazards; utilities operable; no infestation of rodents & vermin. Evidence of preparation for infant's arrival (clothing, furnishings, formula)	Home rel. clean (see a) but no evid. of prep. for infant's arrival	Home unclean w/safety or health hazards; no evidence of prep. for infant's arrival

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN'S SERVICES

ASSESSMENT GUIDE FOR RELEASE TO RELATIVE FOR INFANTS PRENATALLY EXPOSED TO DRUGS

List infant(s) to be placed and potential relative caretaker's name and relationship in Part A. Assess the potential relative caretaker for each risk factor and check the appropriate risk level (Low, Intermediate or High). Write N/A if the factor does not apply or the information is unknown. Write analysis of risk in Part C.

A. Child(ren) ______________________ ______________________

Relative's name ______________________

Relative's relationship to child ______________________

	B. FACTOR	LOW RISK	INTERMEDIATE RISK	HIGH RISK
CHILD	The risk factors for this child are assessed on the Assessment Guide for Infants Prenatally Exposed to Drugs. Please refer to that Guide for specific information and risk levels on this child.			
RELATIVE	1. Relative's drug/alcohol use			
	2. Relative's history of abuse/neglect/violence			
	3. Relative's physical/intellectual or emotional abilities			
	4. Relative's level of cooperation			
	5. Relative's parenting skills and responsiveness to infant			
	6. Quality of relationship between relative and parent			
ENVIRONMENT (P & S)	7. Relative's ability to protect child			
	8. Relative's access to medical resources			
	9. Relative's living environment (furnishings/health/safety)			

C. CSW analysis (consider risk factors and relative strengths)

____

____

____

____

____

CSW ______________________ Date __________

ASSESSMENT MATRIX FOR RELEASE TO RELATIVE FOR INFANTS PRENATALLY EXPOSED TO DRUGS

The risk factors for the child are described on the Assessment Matrix for Infants Prenatally Exposed to Drugs. Please refer to that Matrix for specific information on risk assessment levels of infants prenatally exposed to drugs.

		FACTOR	(a) LOW RISK	(b) INTERMEDIATE RISK	(c) HIGH RISK
RELATIVE	1.	Relative's drug/ alcohol use	Not known to currently be using drugs or allowing drug use in the home		Known use of drugs or alcoholism
	2.	Relative's history of abuse/neglect/violence	No known history of abuse/neglect or violence in the home		Prior involvement with DCS or law enforcement or a history of abuse/neglect or violence in the home
	3.	Relative's physical/ intellectual or emotional abilities	No intellectual/physical limitations; realistic expectations of child; in full control of mental faculties	Mild physical/emotional handicap; mild intellectual limitations which would not significantly impact ability to care for child	Mod. to severely handicapped; poor perception of reality; unrealistic expectations/perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/mental illness; poor impulse control (i.e., demonstrated evidence of violence in home)
	4.	Relative's level of cooperation	Willingness to work with agency, to follow case plan, and provide for child's special medical and physical needs	Overtly compliant or appears to give "lip service" only; superficial understanding of their role and responsibility	Disinterested or evasive, doesn't believe there is a problem with parent or child
	5.	Relative's parenting skills and responsiveness to infant	Evidence of prior successful parenting	No prior experience with parenting but indicates willingness to acquire necessary skills	Evidence of inadequate prior parenting; unrealistic expectations
	6.	Quality of relationship between relative and parent	Relative supportive of parent/child relationship but able to set limits; acknowledges parent's problem		Unable to set limits with parent and/or denies problem; conflict that will interfere with parent/child relationship or is unable to support parent/child relationship
ENVIRONMENT (PHYSICAL & SOCIAL)	7.	Relative's ability to protect child	Parent's behavior would not compromise safety of child		Parent is violent or disruptive and threatens the safety of the child or caretaker
	8.	Relative's access to medical resources	Has own transportation, own phone; close to medical resources	Access to transportation and a phone	No transportation or phone; substantial distance from medical resources
	9.	Relative's living environment (furnishings/health/safety)	Home relatively clean w/no apparent safety or health hazards; utilities operable; no infestation of rodents & vermin; evidence of preparation for infant's arrival (clothing, furnishings, formula)	Home rel. clean (see a) but no evid. or prep. for infant's arrival	Home unclean w/safety or health hazards; no evidence of prep. for infant's arrival

Acting Chairman DOWNEY. Thank you, Mr. Sosa.

Let me begin by asking you, Ms. Sabol, about the city's budget crisis and the State's budget crisis. What does the mayor's budget and the State budget hold for your agency? Are we going to see less money for dealing with substance abuse and programs like home maintenance and other innovative efforts to try and deal with children?

Ms. SABOL. Unfortunately for New York City, this is an extraordinarily difficult time. For fiscal year 1991, I reduced my budget by $44 million in city tax levy. I have been given a target of over $200 million additional dollars to reduce the budget in fiscal year 1992.

When you have reductions of that size and magnitude, it is bound to affect some of the very programs that we are describing here, which in the near term will have adverse effects on the children and the families, and in the long term will have adverse impact on the same children and families and the quality of life for everyone.

Acting Chairman DOWNEY. Mr. Sosa, you mention in your testimony that the city of Los Angeles and the State of California have budget problems. How is that affecting you, in particular?

Mr. SOSA. Well, we took a $23 million hit this last fiscal year, and the result has been that our provision of services remains where it was 5 years ago. It also means that we will only be providing the minimum protective services and not allow any expansion of any innovative programs to maintain families together. What we will end up doing is providing CPR, but no followup, no rehabilitation.

Acting Chairman DOWNEY. Well, I think that is going to be of major concern to members of the committee and to members of Congress. If we decide to expend more resources—and it is my hope that we will—they must not wind up just going to make up for the fact that the States have decided to cut these human services budgets.

I know both Governor Cuomo and Mayor Dinkins, and I appreciate the difficulties they are both in, in terms of budgets. But there is no excuse for reducing these types of services to children. The problem is worse, as you have documented, not better. Taking money from an already bad situation can only exacerbate the problem, is that not so?

Ms. SABOL. We absolutely agree, and one thing that I can say is that the mayor has instructed me that when I make the reductions to do all that I can do to—and I will give you the quote—"to protect children." So, as I make reductions, I am looking very hard——

Acting Chairman DOWNEY. How do you do that? Can you explain how you protect children with less money and bigger caseloads?

Ms. SABOL. It is very difficult, and so what I am doing is I am looking at an array of other programs which indirectly will affect children. For example, services we provide to singles who are living in shelters, and services we provide under the rubric of domestic violence. There is almost no decision one can make that will not ultimately have an outcome for children.

Acting Chairman DOWNEY. That is the same in Los Angeles?

Mr. **Sosa**. That is correct. It will be easy to make an investigation, it is going to be easy to remove the child and it is going to be easy to put them in foster care, because title IV-E is open-ended. The problem is going to be that I need the staff and the funds to get that family back together. In other words, we are paying the money out one end and taking the hit on the other end.

Acting Chairman **Downey**. Let's talk about keeping the family together for a minute. Both New York and L.A. County operate family preservation programs, do they not?

Ms. **Sabol**. That is correct.

Acting Chairman **Downey**. What percentage of the families in need are you able to serve in these programs?

Ms. **Sabol**. For New York, I cannot give you a specific percentage, but I can tell you that it is very small. We have some very small programs in several of the boroughs, and nowhere does it meet the needs. The State——

Acting Chairman **Downey**. Do you serve 1 percent, 2 percent, 3 percent?

Ms. **Sabol**. I would certainly say less than 5 percent.

Acting Chairman **Downey**. Less than 5?

Ms. **Sabol**. Yes.

Mr. **Sosa**. It is the same in Los Angeles. The family preservation projects amount to about 2 percent of our total staff providing these services.

Acting Chairman **Downey**. Do you think that family preservation, if we decided to make a big investment, could make a big difference?

Ms. **Sabol**. Absolutely.

Mr. **Sosa**. A tremendous difference.

Acting Chairman **Downey**. Why are you not spending more money on it?

Mr. **Sosa**. Well, we are mandated to provide 96-272 services, but the problems are different. 96-272 was crated 10 years ago. While we can intervene in emergency response and we can put children in foster care, those kinds of solutions have not diminished child abuse, and those kinds of solutions have not taken are of the problems of these children.

Acting Chairman **Downey**. So, is it fair to say—and I do not want to put words in your mouth—is it fair to say that, while we know that family preservation programs work, you are too busy doing the nuts and bolts jobs of protecting children from abuse and neglect, and dealing with adoption services to the extent that they can be dealt with, to be able to do anything creative or innovative?

Ms. **Sabol**. I think there is an additional factor. Family preservation does work, but it does not negate the need for a whole array of other services. We are investing significant dollars in a whole array of other preventive services at State and city expense, and it is very difficult to take from that and put into family preservation. We need a broader participation between the State, the city, and the Federal Government, and I think that would better allow us to do that.

Acting Chairman **Downey**. I had a conversation with Chairman Miller the other day, who was instrumental, as you know, in writing the 1980 law that we currently live under, and he was suggesting to me that there are places in California—and I do not know if this is true in New York—where they have one point of entry for all types of children who have problems, whether they have substance abuse, criminal justice, or mental health problems. All of the resources are pooled together so that the child and ultimately the family are dealt with by a battery of programs. He said one of the biggest problems that the States have is mixing and matching Federal dollars.

Forgive me for not explaining in more detail the program that he was talking about, but maybe you are familiar with it. It seems to me that there is widespread interest here in the Congress in trying to give you not only more resources—obviously, we are limited in what we can provide—but enormous flexibility, so that you can use all of the services available to better serve the family. Could you respond?

Ms. **Sabol**. For New York, we do not have the one-stop shopping concept. However, Mayor Dinkins has mandated us to do neighborhood based services. I would simply reinforce your point, it would be enormously helpful to States and cities, if we could be given some easement of some of the administrative requirements, particularly under the eligibility requirements for each. It would make a significant difference in what we could do on behalf of these children and families.

Mr. **Sosa**. I think what you are referring to, sir, is a pilot project in several counties in California, in which the counties are allowed a certain percent of their foster care moneys to be invested upfront for family preservation.

Acting Chairman **Downey**. That is correct.

Mr. **Sosa**. Those pilots have proved very successful. State legislation will be expanding those to more counties. There is a sanction, if you do not reduce your foster care population by a certain percentage, then the moneys become county expense only. Nevertheless, the concept is good in us investing the up-front moneys, just like the intent of 96-272 was, was to provide preplacement prevention services and IV-B moneys up-front.

Acting Chairman **Downey**. What if we gave you all of the IV-E money and all of the IV-B money, increased it and let you spend it how you wanted to? I mean we would have to make some guidelines, but would that be of help to you?

Mr. **Sosa**. I think we would gladly accept the money. [Laughter.] But I think we would be looking at what kind of cap you are going to put on this.

Acting Chairman **Downey**. They want me to throw some balls at your head here, instead of these pitches over the plate.

Let me get to my other colleagues. I have taken too much time. Mr. Shaw.

Mr. **Shaw**. Your last question has me a little off-balance. [Laughter.]

I was particularly interested, Mr. Chairman, in the question that you asked the witnesses with regard to new money that might come down from the Federal level. We at the Federal level are very concerned that the cities, States, and local government would not simply use Federal money to subsidize their already serious budgetary problems and to make up for local and State shortfalls, because we have a tremendous deficit ourselves. We are all singing out of the same hymn book, when it comes to deficits, loaded budgets and similar problems.

So, I think that one of my main concerns, and I believe it is going to be one of this committee's main concerns, is that we do not just simply put money out there that can be used to fill the gaps that you are finding in your own budgets.

Ms. **Sabo**. If I might respond just for a moment, just to clarify, when I talk about the difficulty in eligibility, the administrative requirements on eligibility, I am really not talking about new money, in a sense, because we could do things that are not good for children and make them eligible. So, in effect, we are not talking about new money. What we are talking about, or one of the suggestions that I am making, is simply to change the rules.

Mr. **Shaw**. I understand it. I have been in city government, having been mayor. I remember one Federal program where we could get some money to hire more policemen if those policemen would stop people and ask if they would like to take a breathalyzer test. It was one of the dumbest programs that I think I have ever seen, but it was a way that we could hire more policemen, and we had our policemen stopping people and inviting them to take a breathalyzer test, just to fill the requirements of that grant.

I would hope that you who are on the city level would critique the regulations, critique that part of the law that you think is not helpful and is simply burdening you with more redtape. Then submit your critique to the committee, so that we can look at this very closely because I think this is an area that we certainly should take a very close look at. Obviously, we do not want to take all of the requirements off. In fact, you might find us even building some future requirements in, but it would be wonderful if we could do that in cooperation and partnership with State government.

One thing I notice that was missing from the testimony, and it may be because it is not really within your shop, but it is certainly within your sphere of interest, and that is what are we doing about repeat pregnancy by drug addicted mothers. In my opening statement, I made reference to the fact that last year our subcommittee had a hearing out at D.C. General Hospital. We found that many of the mothers now were delivering to the hospital their third cocaine addicted baby, then just simply disappearing again for another year. I would suspect that were we out at the hospital this afternoon, they would be talking about the fourth addicted baby that is being abandoned at the hospital.

What are we doing, as far as prevention of pregnancy? Ms. Sabol, you spoke of teen mothers and caring for them. Obviously, we do have an obligation to give whatever assistance we can, but perhaps we have an obligation also to prevent teen pregnancy. What programs are out there, particularly concentrating in your reply on programs to prevent drug-using mothers from being repeat offenders and coming back year after year with deformed cocaine addicted babies? I present this to both of you.

Mr. **Sosa**. Well, in my testimony that I submitted, we ask that you encourage the health field and the drug program field and the social services systems to work together to provide an integrated system of care and provide incentives to accomplish this.

You are absolutely right, that oftentimes we do see repeaters. What we need to do in Los Angeles County is to ensure that some of the Federal moneys in Medicaid, for example, or special program moneys have some words in there that give these kinds of mothers priority in service slots, so once they are in the hospital, once we know we can identify them, we have a better hook on them.

Mr. SHAW. Have you given any thought to somehow preventing them from having any more kids?

Mr. SOSA. I am sorry?

Mr. SHAW. Preventing them from having any more kids, counseling them on birth control, counseling them on other things that might be able to be done to stop this tragedy? I think there is a glitch in the law in that a woman that wants to have a tubal ligation under Medicaid—unless we got this out of it last year—I know we were talking about it, either last year or the year before last—must endure a waiting period after she give her consent. This waiting period extends beyond her hospital stay, so then she goes out of the hospital and is not about to come back and take care of that until she is ready to delivery another baby, which, in all probability, is going to be drug addicted.

Those are tough questions and, believe me, as a politician, those are tough questions for us, as public officials, to address, but we had better do something about it, because there is a terrible tragedy out there, involving these kids who are going to have just a dreadful life ahead of them.

Ms. SABOL. I agree with you, Congressman, that we must provide family planning services, we must provide education. In New York City, we have a program that is called New York-New York Connect. It is a State and city collaborative project, where we have selected certain areas of our city where we know there are high concentrations of poverty, where we know there are high substance abuse rates. We have targeted certain hospitals, and while the mother is in the hospital, we offer an array of services, including priority for substance abuse.

I think at the bottom line, one of the problems is, as my colleague has described, there are not enough drug treatment slots for women who want to receive drug treatment and, therefore, become rehabilitated, so at the point that they would have the next pregnancy, they would have been rehabilitated.

So, we are working on this initiative and it is just beginning, so I am not prepared to give you any outcome data, but we are targeting on women at the point of delivery, providing the kind of health education, family planning information, and linkage to services that you were just describing, and we are hopeful that it will have a positive impact in those four communities in which we will be working.

Mr. SHAW. Those things are very good, but neither one of you have answered my question as to pregnancy prevention. What are we doing about the person who has delivered their second cocaine baby? Are we doing anything to prevent pregnancy, so that we do not see the third, fourth, and fifth baby come in the same way?

Ms. SABOL. I would certainly be interested in any of your suggestions. I do not know of a specific pregnancy prevention program, except under the rubric of offering and providing family planning services, counseling services. You know, there may be——

Mr. SOSA. That is correct.

Mr. SHAW. So, there is no direct pregnancy prevention program in either Los Angeles or New York at this particular time, am I correct in that?

Ms. SABOL. Nothing with the specificity with which you are asking, that is correct.

Mr. SOSA. Right.

Mr. SHAW. Thank you.

Acting Chairman DOWNEY. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I was sitting here thinking, I started working with CPS kids 30 years ago, and I had not thought about how long it had actually been. The profile has changed in these kids over the 30 years that I have been involved.

In listening to Mr. Shaw's question, the first question that came to my mind was can you tell me what the average caseload of a CPS worker or foster care worker is in New York and Los Angeles today?

Ms. SABOL. We have worked very hard in New York and have our protective diagnostic caseloads down to 1 to 14, and that is a real breakthrough for us, and we felt we had to have caseloads of that size, for the very issues that you are raising, the complexity of the cases, the number of children who are in the case, and so we are down to that.

Mr. MCDERMOTT. That is in the diagnostic unit. What about——

Ms. SABOL. In diagnostic, yes.

Mr. MCDERMOTT. Do you have a unit they are turned over to, once a case is put out into foster care?

Ms. SABOL. Yes, and I will look at my data and tell you what that caseload is.

Mr. MCDERMOTT. How about Los Angeles, what is their caseload?

Mr. SOSA. Our entry point is our emergency response system, and our average caseload is running 1 to 21, 21 new cases per month per social worker. We are hoping it bring it down to 15, if the budget holds. In the back-end, once the case is in the foster care system, our caseloads are running, on average, about 52 per worker, 52 children per worker.

Mr. MCDERMOTT. It sort of strikes me that part of the answer to Mr. Shaw's question revolves around the question, if you have a big caseload, the question of whether you have time to sit and counsel people and not simply do the paperwork necessary, makes it almost impossible to do the kind of things that he is suggesting, in terms of dealing with people's pregnancy possibilities for the future and getting them to accept birth control. I wonder, did you look at your figures and tell me what——

Ms. SABOL. Our caseloads, fortunately, are not nearly as high as Los Angeles, and our foster care caseloads are like 1 to 22.

Mr. MCDERMOTT. So, you manage to keep it 1 to 22. Do you know what your foster care caseload is, once you get beyond the CPS entry point?

Mr. SOSA. Like I said, it is about 1 to 52.

Mr. MCDERMOTT. One to 52.

Mr. **Sosa**. Children, not families.

Mr. **McDermott**. Let me ask another question, because as I look at this whole problem, when we had a CPS system that has been functioning for some time, inadequately functioning, I might add, but nevertheless functioning, and then we had this enormous wave of drug problems and we have created another system, a drug treatment system that has been kind of grafted onto what was already there, I would be interested in hearing from you the points at which those two systems don't work, where you have the mother who comes in for drug treatment and she somehow does not get into the other systems, what kinds of impediments are there to actually making those systems work.

You are on the front line. We sit up here and pass laws and we never quite know how it works out in the field, so I would like to hear what you have to say on that.

Mr. **Soda**. I will give you an example. Once we take a child into custody and he goes to court, the mother goes to court also, the judge may require, as part of family reunification, that the mother go to drug rehab or detox or testing, or both. Drug rehab programs in L.A. County have a waiting list of about 6 weeks, drug testing is very scarce and it costs money.

Consequently, 6 weeks for this mother or father to wait for 6 weeks until they can detox or wait 6 weeks until they can enter some kind of a rehab program, in the meantime we have this child in foster care, the bond breaks, the opportunity to deal with the mother during the crisis falls apart and the mother goes back into the environment, and, consequently, we do not have that hook on her any more.

In maternal care, even if we identify that the mother is on her second child or third child, getting her hooked up to a maternal and infant care program and some prenatal care is very difficult, because she may not meet the welfare requirements and get a Medicaid card, or else we cannot follow her up to ensure that she attends or that she goes to the prenatal program. Consequently, all we can do is wait until such time as she has the child, and then we respond.

Mr. **McDermott**. Do you have any accelerated detox program for women who are pregnant when they are picked up for drugs? Do you immediately put them into a detox program to make sure that they do not produce a drug addicted baby?

Mr. **Sosa**. No, we do not.

Mr. **McDermott**. You have no system like that?

Mr. **Sosa**. No, sir.

Ms. **Sabol**. At several of the municipal hospitals, they do have detox programs. There is a linkage between the detox program and the prenatal care program, so to the degree that the pregnant woman is in a prenatal care program, she will be immediately hooked.

Mr. **McDermott**. How about if she is picked up by the police in a drug abuse situation and taken into court? If she is pregnant, how quickly does she then get into the other system?

Ms. **Sabol**. I cannot give you a timeframe on how quickly. I would make three points: First, the major problem is too few drug treatment slots and detoxification slots that are focused on women and that are focused on the current epidemic, which is the crack cocaine epidemic.

Second, I would say that what we are hoping to do is to move on the front-end of that, by working with women who have just delivered their babies, and that is the New York-New York Connect program, to make sure that they are attached to drug treatment and that they get priority.

The third thing I would say—and this Congress is to be commended for—is increasing the Medicaid eligibility up to 185 percent of poverty for pregnant women and their children up to 1. I believe that has been very valuable in making sure that they have Medicaid eligibility and, therefore, we can get them into the few nonresidential drug treatment slots that exist, but it is a major problem, too few drug treatment slots for women.

Mr. McDermott. Has New York implemented fully up to 185 percent?

Ms. Sabol. Yes, we have.

Mr. McDermott. You have?

Ms. Sabol. Yes, we have.

Mr. McDermott. I am going to have to find out data for other States. I think New York is to be commended, in the midst of all your crises.

How about California?

Mr. Sosa. No, sir, we have not.

Mr. McDermott. Where are you up to?

Mr. Sosa. I do not know.

Mr. McDermott. OK. So, you have not used the full implementation that we allowed under the law?

Mr. Sosa. That is correct.

Mr. McDermott. Because of the California budget deficit, I would assume there is no money.

Ms. Sabol. I might add that we did it before the current continued downhill slide.

Mr. McDermott. I would watch carefully the Ways and Means Committee of the New York Assembly, as they try and save some money.

Thank you, Mr. Chairman.

Acting Chairman Downey. Thank you, Mr. McDermott.

Let me just ask, do either New York or California have the capacity to treat mothers who have drug or alcohol addiction while they retain their families?

Ms. Sabol. Yes.

Acting Chairman Downey. How many people are you treating, what percentage of the total?

Ms. Sabol. Again, it is a very small percent. The family rehabilitation program that I mentioned is tying preventive services, which is fully funded by State and city dollars, with drug treatment, so that the family gets both. We keep the family together. We are in the process of developing several hundred new drug treatment residential slots, where the mother goes in with her children, and if you give me just a few seconds here, I could give you some specific data about that.

Acting Chairman Downey. Mr. Sosa, could you tell us if Los Angeles has that capacity?

Mr. **Sosa**. Yes, we have three high-risk units that operate, as I said earlier, when intensive services to high-risk drug exposed families and their children, and there are only 3 out of 6 regions that have these units, and we are running about 240 cases total in those 3 units at any point in time.

Acting Chairman **Downey**. What happens to the families that are not in this program? The children, I assume, are taken from the home and put in foster care, is that the alternative?

Mr. **Sosa**. They get the best service we can afford, with the caseloads that we have.

Acting Chairman **Downey**. How do you determine who gets in the program and who does not?

Ms. **Sabol**. A lot of it has to do with the availability of a slot at that particular time.

Acting Chairman **Downey**. Is it first come, first served, is that it?

Ms. **Sabol**. The availability of a slot, the risk of the child and the probability of success of the mother in the program. Just to give you the data to show you that we are just beginning to make inroads, in the residential program that we are just beginning, it will be 45 mothers and 55 children, and in the other program it will be 12 adolescent mothers and 12 newborns, so you can see that it is very small, we are just beginning.

Acting Chairman **Downey**. It is tiny.

Mr. **Sosa**. What we are looking at, in our assessment, is mother going to be around or is she in jail, is the mother workable, does she have family support in the community. That gives us a better update.

Acting Chairman **Downey**. What is the half-life of a CPS worker? Do you have turnover problems with child protective caseworkers?

Ms. **Sabol**. It is interesting, in this particular economic climate we are finding it is affecting CPS workers, it is affecting——

Acting Chairman **Downey**. They are not leaving?

Ms. **Sabol**. They are not leaving, but it does not mean that the job is not as difficult as it always has been. What we are trying to do is to build in supports for those workers to minimize the burnout.

Mr. **Sosa**. We are finding it a little bit different. Our attrition rate has remained pretty steady, about 14 percent a year. But what is significant is that the social workers that are involved in these high-risk units, even though they are very highly intensive kinds of services, with very sad cases, they stay, because their work has a lot more meaning than just trying to put the finger in the dike.

Acting Chairman **Downey**. Thank you both very, very much for your fine testimony. Help is on the way.

Ms. **Sabol**. Thank you.

Mr. **Sosa**. Thank you, sir.

Acting Chairman **Downey**. We will next hear from Hon. Ernestine S. Gray, who is a judge of Orleans Parish Juvenile Court, in New Orleans, La.; and from the American Bar Association, Judith Larsen, special consultant, Center on Children and the Law.

Your Honor, Judge Gray, if you would begin.

STATEMENT OF HON. ERNESTINE S. GRAY, JUDGE, ORLEANS PARISH JUVENILE COURT, NEW ORLEANS, LA.

Judge GRAY. Thank you, Mr. Chairman.

My name is Ernestine Gray, and I am a juvenile court judge from Orleans Parish, in New Orleans, La. I want to take this opportunity to thank the committee for providing me with a chance to appear this morning to address some of the issues that I and my colleagues across the country face on a daily basis.

The assistant secretary of the State welfare agency indicates to me that, while the actual number of cases in Louisiana, in Orleans Parish, has not risen because of the substance abuse problem that is so pervasive, the number of cases involving drug problems has increased.

Of the 23,000 statewide investigations involving noncustody child protection services, some 7,666 come from Orleans Parish, and of that number, approximately 80 to 85 percent are identified as having substance abuse in the family. And of the 2,500 families with children in custody on any given day, 833 of them are in Orleans Parish, and 50 percent or 416 of them are identified as having substance abuse in the family.

Orleans Parish is the major urban area in the State of Louisiana, and it accounts for about one-third of all the child protection investigations and cases in the State.

The number of children born exposed to illicit drugs has grown dramatically over the country since 1988. However, drug exposed children are not born exclusively to poor and minority families, but poor and minority families or mothers face a much greater risk of having their children removed from their care, when no other effective interventions are available.

In one recent study, the number of poor and minority women who tested positive for drugs, when hospitalized for childbirth, was slightly lower than the number of white middle-class women. Yet, the same study showed that poor and minority mothers were 10 times more likely to have their infants removed from their care.

This problem calls for a new cultural sensitivity in decisionmaking about these children and their families. To ensure equity in decisionmaking among diverse cultural and racial groups, increased understanding is needed of the cultural and economic strengths and weaknesses of each family, regardless of class or color. Families are important to all children. Strengthening families is a goal second only to protecting children, and every reasonable effort should be made to do both.

In making the reasonable effort determinations, judges try to take a balanced approach. The presence of a substance abuse problem does not automatically equal removal of the child. If it is possible to safely maintain the child in the home by providing intensive in-home services to the family, that is our preference. However, the judges' decisions may be compromised, due to the lack of availability of preventative services to families.

It is most frustrating to determine and be told that a family needs a particular service which is not available, or if it is available, that the waiting list is 6 or 8 weeks or maybe even longer.

Sometimes it is impossible to get information about the waiting list itself.

The courts across this Nation are struggling to implement Public Law 96-272, although it has been on the books for some 10 years. However, the cases that we face are very challenging and complex, and it is sometimes difficult to conduct the required periodic reviews in a timely and meaningful manner. Courts need more money for family preservation services and funding for the courts which will help them to be able to meet the burdens placed on them by Public Law 96-272.

A critical component of any preventative service system is treatment. Treatment resources are needed of all sorts. Treatment does work, but in order for it to work, it has to be available, and it must be available for everyone.

Finally, while this subcommittee is not designed to address these issues, I think we must be concerned about what happens to the families after we have intervened in their lives, and they have successfully completed treatment.

If they must return to the same conditions and environments as existed prior to our help, our help and assistance will all be for naught. We must make an effort to address the reasons substance abuse is a part of so many lives. For me, it seems that we need to make sure that adequate, affordable education is available to all our children, and that jobs are available for their parents.

We must make efforts to address the hopelessness and despair that is a part of the lives of so many families that come before the courts. This I know is a long-term solution and a long-term process, but we must not lose sight of it, as we struggle on a day-to-day basis to deal with the crisis situation.

I commend the committee and I stand ready to answer any questions that you might have for me.

[The prepared statement follows:]

TESTIMONY OF JUDGE ERNESTINE S. GRAY
ORLEANS PARISH JUVENILE COURT, NEW ORLEANS, LOUISIANA

In 1980, Congress took an important step to keep troubled families together and passed the Adoption Assistance and Child Welfare Act, P.L. 96-272. The law underscored three important principles, (1) the prevention of unnecessary foster care placement; (2) the reunification of children in foster care with their biological families, when feasible; and (3) the timely adoption of children unable to return home.

Among its major provisions, the Act requires judges to determine whether "reasonable efforts" have been made to enable children to remain safely at home instead of being placed in foster care. Judges must also ensure that "reasonable efforts" are made to reunite children with their biological parents.

As gatekeepers to the nation's foster care system, juvenile and family court judges have worked to implement the "reasonable efforts" requirement, to encourage services to protect children in their own home, and to prevent the unnecessary removal of children from families. Continuing progress towards these goals is being hampered by a startling increase in substance abuse (alcohol and other drug abuse) among women of childbearing age that has overwhelmed the child protection, treatment, and other human service sectors nationwide.

The number of children born exposed to illicit drugs has grown dramatically to an estimated 375,000 children in 1988.[1] Drug-exposed children are not born exclusively to poor and minority families. But poor and minority mothers face a much greater risk of having their children removed from their care when no other effective interventions are available. In one recent study, the number of poor and minority women who tested positive for drugs when hospitalized for childbirth was slightly lower than the number of white, middle-class women. Yet the same study showed that poor and minority mothers were 10 times more likely to have their infants removed from their care.[2] The problem calls for a new cultural sensitivity in decision-making about these children and their families. To ensure equity in decision-making among diverse cultural and racial groups, increased understanding is needed of the cultural and economic strengths and weaknesses of each family, regardless of class or color. Families are important to all children. Strengthening families is a goal second only to protecting children and every reasonable effort should be made to do both.

Three basic types of professionals witness the impact of substance abuse on children and families on a daily basis. The first group includes public health, medical and treatment service providers. The second group includes social service workers, and the third group consists of our nation's juvenile and family court judges. It is each judge's responsibility to ensure that "reasonable efforts" are made to preserve and reunify the families of substance-exposed children. It is each judge's legal responsibility to examine the impact of substance abuse on poor and minority populations and act to ensure racial equity and program effectiveness in both policies and practices.

The current national trend in cases involving substance-exposed infants and children is to redefine "reasonable efforts" to mean refocused efforts. Such a redefinition is necessary because our services system has not previously been constructed to deal with mothers and children with substance abuse problems. New and different types of family-focused services have been created that are both effective and economical. These proven, new family preservation programs feature a multidisciplinary approach and early intervention with families. I have no doubt that treatment can work. Substance abuse can be ameliorated and children can safely remain with their families in many cases. The preservation of one family of one drug-exposed infant can help to ensure the health and safety of present and future siblings and, possibly, future generations. When this can be done for less cost than would otherwise be incurred for the unnecessary dismemberment of the family, it makes a compelling case for expansion of such efforts.

---

[1] Select Committee on Children, Youth, and Families, U.S. House of Representatives, "No Place to Call Home: Discarded Children in America," p.7, (November 1989).

[2] Ira J. Chasnoff, Harvey J. Landress, and Mark E. Barrett, "The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida." New England Journal of Medicine, Vol. 322, Apr. 26, 1990, pp. 1202-06.

Public health, medical and treatment service providers, social service workers, and juvenile and family court judges nationwide must prepare to face drug-related dependency cases in increasing numbers. As part of my service as a member of the National Council of Juvenile and Family Court Judges, I have recently been at work on a Protocol for Making Reasonable Efforts in Drug-Related Dependency Cases. The purpose of this protocol is to provide model questions to guide risk assessment and identify the family preservation service needs of drug-exposed families. The overriding principles which have governed the development of this protocol include:

- Prenatal substance abuse may create substantial harm or risk of substantial harm to a child. To make placement decisions requires good medical risk data on the mother and infant, as well as the assessment of parental capacity for responsible child rearing.

- Prevention of substance abuse by all family members is the interdisciplinary goal of public health, medical and treatment service providers, social service workers, and juvenile and family court judges alike. Yet pregnant women have special medical service needs. Accordingly, comprehensive services, including preconceptual and prenatal substance abuse programs and all related medical services should be made available on demand to all women of child-bearing age.

- A child should be removed from the home only upon a showing that there is a substantial risk of harm to the child that cannot be ameliorated through family preservation services. Decision-makers should balance the risk of harm to the child against the known harm inflicted upon children through removal from their families. Due consideration should be given to the potential for the active intervention of family preservation services. These services can be designed to assess risk, restructure both family behavior and available caretaker resources to safely preserve families.

- Juvenile and family court proceedings are not necessary and probably not desirable in most incidences of substance-exposed infants. Juvenile and family courts should be involved only when alternative services have not been offered or effective in providing support to the family and protection for the child. Where substantial risk of harm remains, the juvenile and family court has jurisdiction to assess the level of risk and determine what is in the best interest of drug-exposed children and mothers.

- The criminal prosecution of mothers for alcohol and other drug abuse during pregnancy may not be consistent with the goals of civil proceedings or the best interest of the child and may even inhibit treatment or expose the child to unnecessary family disruption and attendant harm. Any criminal court proceedings should be coordinated with proceedings in the juvenile and family court.

- Juvenile and family court judges should play a leadership role in working with key people from all three branches of government, the public health, medical and treatment services communities, and the private sector to develop a comprehensive continuum of family-focused, multidisciplinary drug treatment and family preservation services.

- Public health, medical and treatment service providers, social service workers, and juvenile and family court judges should work together to ensure substance abuse treatment upon demand, with the assurance of non-punitive action.

- Treatment programs for drug-exposed children and mothers should be comprehensive, multidisciplinary, family-focused and child-centered.

- Health and treatment service providers, social service workers, juvenile and family court judges and others should recognize the relationship between substance abuse and the rising incidence of HIV exposure and other sexually transmitted diseases (especially Hepatitis B and syphilis) and other infections (e.g., tuberculosis).

- Drug and substance abuse treatment is a political and ideological issue. New attempts to understand and treat addiction should draw upon old traditions, but should re-emphasize the importance of the family as a crucial unit of support and nurturance that cannot be effectively replaced by strangers or congregate care. Effective treatment is linked to practical help for mothers, fathers, and families, such as transportation, housing, child care, nutrition, education, job training and health care.

> In cases in which substitute placement of children is unavoidable, sensitive selection of placement and transition into care, as well as continued and regular contact between family members should be maintained and family reunification achieved as quickly as possible. For children unable to return home, permanent adoptive homes should be secured as quickly as feasible. The crucial nature of the developmental years of children and their need for stability in care and nurturance should encourage timely decision-making on termination of parental rights where indicated.

The protocol is intended to prevent the unnecessary removal of drug-exposed children from their families, and is intended for use by judges; social service agency personnel; public health, medical and treatment service providers; legislators; attorneys; law enforcement personnel; and volunteer child advocates. Key people from all three branches of government and the private sector must work together to define, provide, and enforce "reasonable efforts" toward enabling drug-exposed children to remain safely at home instead of being placed in foster care, or to rejoin their biological families when feasible.

Thank you for this opportunity to address the special problems which juvenile and family court judges confront in attempting to render justice for children and families affected by substance abuse.

Acting Chairman DOWNEY. Thank you, Judge Gray.

Ms. Larsen.

STATEMENT OF JUDITH LARSEN, SPECIAL CONSULTANT, CENTER ON CHILDREN AND THE LAW, AMERICAN BAR ASSOCIATION

Ms. LARSEN. Good morning, Mr. Chairman and members of the subcommittee.

I am Judith Larsen. I am a practicing attorney in neglect and abuse cases in the District of Columbia, and a special consultant to the American Bar Association's Center on Children and the Law, on matters of parental substance abuse.

At the center, we observe three areas of the law that are particularly vulnerable to change through the insertion of drug-specific language in State laws. Those areas are: First, controlling the behavior of the pregnant woman; second, requiring or permitting the use of positive drug tests, either as a basis for reporting or for prosecuting a neglect case; and third, earlier removal of children from homes and easier termination of parental rights procedures.

Briefly, we find diminishing interest in the States for using the civil neglect and abuse laws to control behavior of the pregnant woman, and this is mirrored on the criminal side by what we view as unsuccessful efforts to do so through the criminal laws.

Instead, we find States looking seriously at putting increased funds into programs for pregnant women and early intervention programs, to attract voluntary compliance. And from what we have seen of those demonstration programs or those private programs in States across the Nation, we have high hopes for success of these efforts, and we applaud them. We note that a number of bills have been or are about to be introduced in this Congress that would increase funding for such programs.

In the second area, the use of positive drug tests, first of all, we would note that Public Law 96-272 places no barrier to the use of a positive drug test as evidence in a neglect case.

Furthermore, we would note that those few States, maybe a half dozen, that have amended their laws to permit or require the use of positive drug tests, perhaps equating them to a neglect by saying that a parent with a positive drug test is presumptively neglectful, have run into two difficulties.

The first is that it is very difficult to draft a provision that accurately reflects the scientific basis for a positive drug test. There have been linguistic problems in every State.

The second is that we are now much more sophisticated than we were, for example, in 1985, and we know that there are limits to what a positive drug test can show us and we know how many children will be missed by using positive drug tests, since the time window is so short. In other words, with cocaine, you would have to have taken drugs 72 hours before the test, in order for it to actually show up, so that those children that you saw in the nursery in Washington, D.C. might never show positive on a drug test, but still would have been damaged by ingestion of drugs early in the pregnancy.

So, we would see no compelling reason to develop a Federal law that would permit or require the use of positive drug tests, since there are scientific problems with their use, and in any case they are already permitted under Public Law 96-272.

As to the third area, the easier termination of parental rights and earlier removal of children in danger, we would also observe that Public Law 96-272 puts no barrier in front of the social worker or law enforcement officer to removing a child who is immediately in danger. In other words, under the Federal law and under the State laws that reflect those Federal provisions, there is no requirement that if a child is obviously in danger, you must nevertheless leave that child in the home in order to bring in services that would help keep the family together.

So, why is it that children are still dying and are still being injured in homes after reports have been made to the child welfare agency? It is our observation that there are inadequate training and inadequate resources; inadequate training not just of the social worker and the other professionals that immediately come in contact with the child, but also of the judiciary and the lawyers that are involved. They cannot always recognize a substance abuse problem, and thus cannot bring the right resources to bear on it.

The State of Rhode Island had four fatalities last year. The Child Advocate investigated the causes of those fatalities, and in no case was it found that there was a problem with the law. In every case, it was found that there was a problem with inadequate training or inadequate resources.

As far as revising a Federal law to radically change the time within which one must make a decision about a boarder baby, for example, we have grave concerns about moving too quickly in that area. For one thing, Public Law 96-272 again places no barrier to making an early decision about that. There is the 18-month deadline as an outside parameter, but no required waiting period that would prevent swift decisions.

The problem we see is that States are inadequately or differently funded, so that State A may have alot of resources to bring to bear on making a good early decision about an abandoned baby, but State B may have no resources and end up just being a policing agency that identifies substance-using parents and removes the children.

So, what we at the Center on Children and the Law would prefer to see, if Congress is moved in this direction, would be demonstration projects, so then we can scrutinize it and see if there are any problems, before we make any particular changes.

I also stand ready to answer your questions, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF JUDITH LARSEN
AMERICAN BAR ASSOCIATION CENTER ON CHILDREN AND THE LAW

Mr. Chairman and Members of the Subcommittee:

I am Judith Larsen, Special Consultant to the Center on Children and the Law, a program of the American Bar Association, Young Lawyers Division. As a private attorney I represent children and their families in neglect and abuse cases in the District of Columbia. For the ABA Center on Children and the Law I train judges and social workers to identify and respond to parental substance abuse issues in child neglect and abuse cases. Today I am here to answer your questions about whether federal laws should encourage changes in state child abuse and neglect laws to provide better protection for children threatened by parental substance abuse. My comments have not been approved by the House of Delegates or the Board of Governors of the American Bar Association and, accordingly, should not be construed as representing the positions of the Association.

State child neglect and abuse laws developed over the past two decades tend to contain broad definitions of neglect and abuse that describe how the child welfare agency is to protect the child from immediate harm and develop a permanent, safe home - preferably with the natural family - without undue delay. These state laws tend to be simple and flexible.

From time to time there are waves of anxiety about social issues that bring those laws under state legislative scrutiny. Parental substance abuse is the most recent of these social crises. It has brought to the courts not only unprecedented numbers of neglect and abuse cases [1] but a younger population of victims -- and some analysts fear a more intractable family dysfunction than we have seen in the past. [2] Again, we are asking whether the broad definitions of neglect and abuse in the older laws are flexible enough to meet the new crisis, or whether child welfare agencies and courts must be given more precise directions to enable swift identification and protection of children at risk from parental substance abuse. Are we now at a national juncture where it is apparent that the goals of PL 96-272 -- combining protection of children and support for families -cannot resolve the new problems?

Luckily we are not without a national compass. Quite a few, state legislatures have responded already to their constituents' anxieties about drug abuse by adding drug-specific language to definitions of neglect and abuse and certain new procedures to hasten resolution of these cases. Three aspects of the the old laws have been especially vulnerable to scrutiny and change:

1. Whether the mother's behavior during pregnancy should be controlled.

2. Whether the parent or a newborn should be tested for drugs.

   Whether a positive drug test should be the basis for reporting a family to the child welfare agency.

   Whether a positive drug test should presumptively indicate child neglect or abuse in civil prosecution.

3. Whether it should be easier to remove children from their homes and terminate parental rights.

To what extent have such changes proved efficacious, and are there new problems that the changes themselves create? We have just enough national experience to indicate answers to those questions.

1. Controlling the mother's behavior during pregnancy.

In its civil neglect and abuse laws, only the state of Minnesota has attempted to develop a system for controlling the pregnant woman's ingestion of illegal substances. The system involves reporting her behavior to the local welfare agency, assessing her condition, offering her services, and allowing the local welfare agency to seek civil commitment for drug treatment if the woman refuses proffered services.[3] For the most part, that law is carefully crafted to rest on a professional medical assessment of obstetrical impairment. It is our understanding that, like many states, Minnesota does not yet have drug treatment services fully and immediately available to all of the pregnant women who may need them so that at this point it is not possible to accurately evaluate the impact of the new law on child abuse and neglect cases.

Other states have reacted very cautiously to the approach of controlling the mother's behavior through civil laws. Not only is the subject a minefield of constitutional issues, which have not yet been fully explored by the courts, but a number of states have decided that the same goal can be accomplished by fully funding their drug-treatment programs, and giving priority to pregnant women. The experience of states like Washington and Oregon is that pregnant women will voluntarily enter well designed drug-treatment programs if they are available. That legislative experience has been borne out by numerous drug treatment clinics for pregnant women around the country in which admission is voluntary and the clinics are always full.[4]

In 1989-90 the ABA Center on Children and the Law undertook an analysis of Washington State neglect and abuse laws to determine whether they should be expanded specifically to address the problem of substance-abusing pregnant women. The report was prepared for the state's Division of Alcohol and Substance Abuse in preparation for legislative scrutiny of the issue.[5] After interviewing nearly 50 people representing all kinds of professions and clients in the parental substance-abuse field, we discovered an amazing consensus: the medical model, rather than the punitive model, provides the most efficient route to healthy families. Across all professions there was agreement that the goal should be drug-treatment and counseling, and that the road to that goal should be through adequate and immediately available treatment. The civil child abuse and neglect laws, which in Washington State are on the old model of broad, inclusive language, were judged sufficient by both the bench and the bar to accomplish the care of children at risk. The Washington State legislature has accepted the medical model and been at the forefront of funding drug treatment programs, and prenatal and infant care.[6]

The cautious approach of states toward controlling the behavior of pregnant women through civil neglect and abuse laws is reflected in the emerging trend of criminal law. There have been relatively few criminal prosecutions this year for prenatal behavior. The spate of prosecutions in the prior three years have been mostly dismissed at the trial court level or overturned on appeal.[7]

2. Drug-testing a parent or a newborn as a basis for reporting or prosecution.

The broad, inclusive language of state neglect and abuse laws does not, of course, require or recommend drug testing as a way to develop evidence of a substance abuse problem in the dysfunctional family. A number of state legislatures felt the need to provide guidance to its child protection agencies, prosecutors and judiciary on this subject. No doubt it seemed appealing to have a chance to confirm suspicions of a drug problem with what appears to be scientific evidence: actual traces of specific drugs in the body fluids of either a parent or an infant. One overwhelming question has developed, however, in states where statutes were amended specifically to address drug testing:

> Does the presence of illegal drugs in body fluids prove, or even indicate, neglect or abuse of a child?

The answer to this question will suggest how the drug tests are to be used. If a positive drug test may prove neglect or abuse, it could be placed in the section of the law which addresses how a case shall be prosecuted. If a positive drug test merely indicates a possibility of neglect or abuse, the test would better fit into the part of the law that describes what kind of behavior must be reported to the child welfare agency.

In addition, in every state where changes have been made to insert drug testing language into neglect and abuse laws, there has been a struggle to find the exact language that promotes, rather than impedes, reporting or prosecution.

About 1985, when the crack-cocaine epidemic began to overwhelm our cities, drug tests must have looked like a cheap way to relieve the resulting child welfare crisis. Drug-testing seemed at first to be a litmus test of drug use, almost an alternative to vigorous investigation by the social worker. In 1985 urine toxicology screens carefully conducted were thought to be quite accurate.[8/] It seemed that a positive test absolutely would identify a drug problem, and the child welfare agency need only make a decision about whether to remove a child from the home, and whether to recommend prosecution.

In 1991 lawmakers and lawyers have come to understand more profoundly the medical meaning of a positive drug test. We now know how small a margin of time the test covers -- a mere 72 hours, at the outside, of cocaine use.[9/] We know, therefore, that any infant impaired by a mother's drug use early in the pregnancy, whose impairment is not obvious at birth but is nevertheless a significant retardant to the child's growth and health, would be overlooked through a drug-test. In regard to pregnant women, we know that it is principally the poor, minority women who use public hospitals who are drug-tested, based on hospital protocols that tend to identify them as likely users; therefore, infants born to affluent women substance abusers with private doctors (whose numbers equal poor minority women)[10/] will be missed by most drug tests. We know that drug tests can not distinguish between a chronic and a one-time user, and do not indicate the amount of drugs that were taken. Problems with drug tests lead us to ask these questions:

1. Do drug tests actually reach the heart of the affected populations?

2. Do drug tests promote discrimination against the poor?

3. Do drug tests substitute for necessary, vigorous investigation by the child welfare agency?

No state requires drug testing for all newborn infants. In most states, therefore, drug testing of pregnant women and newborn infants is a matter governed by hospital protocols or policies. Many of these rely on social profiles of the women (and some of these profiles correlate with poverty factors like homelessness, uncleanliness and lack of economic support) as well as on medical information about the mother and child, such as weight, nourishment, head circumference, withdrawal symptoms, and so forth. Drug testing of parents for older children is usually controlled by family courts -- that is, judges may order regular drug testing as a condition for retaining custody, or being permitted visitation of children in an on-going neglect or abuse case. Many neglect and abuse laws specifically permit this, while others are silent on the issue but present no barrier.

Among those states that do address the issue of drug-testing through civil neglect and abuse laws, Minnesota requires that whenever a medical assessment of a pregnant woman suggests use of illegal substances, her newborn be tested and the positive results be reported to the local welfare agency.[11/] In Florida, a "drug dependent infant" is to be reported.[12/] Illinois goes further by equating neglect with the presence of any illegal substance in the newborn for purposes of civil prosecution.[13/]

Each of the states has encountered problem in drafting laws that accomplish the legislators' intent. The experiences of Florida and Illinois are instructive. Florida's reporting law refers to the "physical dependency of a newborn infant" upon illegal drugs -- a matter assumed at the time of the amendment to be provable by a drug test. However, infants can be born with drugs in their system and not be addicted or dependent upon those drugs. Moreover, cocaine does not inevitably produce a withdrawal syndrome like the narcotic heroin, so there is no sure way to show dependency. Physicians, particularly, did not feel that they were receiving adequate guidance about when to report a case.[14] Illinois, after originally drafting a similar provision, revised its definition to refer to "any newborn infant whose blood or urine contains any amount of a controlled substance ... or a metabolite of a controlled substance". To date, in those few states that have amended their neglect and abuse definitions to include drug-specific language, the Illinois language seems to have the most utility.

Perhaps no state has studied the issue of drug-testing more thoroughly than California. The legislature has had consistent access to skilled medical analysis, as well as participation in the perinatal task force by child welfare administrators and lawyers. Therefore, its recent amendment to the reporting act, to be implemented this July, is worth our attention.[15] The new bill requires coordination among public and private hospitals, county health departments and county welfare departments, all of which must develop protocols within the county for needs assessments. The needs assessments tools (which will address both risk to the child and level of required services) are therefore consistent throughout each county. A health professional is entrusted with all pre-reporting tasks for substance-affected newborns. The bill specifically states that a positive drug test of a newborn is not a sufficient basis for reporting child abuse or neglect. Instead, "any indication of maternal substance abuse" including a positive drug test "shall lead to an assessment of the needs of the mother and child." The needs assessment has three purposes:

1. to identify the services that the child and family need with a goal of maintaining the child in the home.

2. to determine the risk to the newborn and the level of intervention and services needed.

3. to gather data and information for health and welfare planning purposes.

It remains within the discretion of the health care practitioner (who may be a medical social worker) whether the case is to be reported to the child welfare agency after the needs assessment is completed. The child welfare agency is spared the burden of an initial investigation, but has the assurance that the health practitioner is working from a needs assessment document that has been approved by the agency.

In sum, we have posed the question whether it is necessary to amend state laws to require or permit drug testing in order to meet the crisis of child abuse and neglect caused by parental substance abuse. Certainly drug tests have some utility in identifying drug-users. Under careful laboratory conditions, the simple urine toxicology screen, if confirmed by another different more sophisticated test, can indicate very recent drug use. Moreover, for newborns, new methods of testing, for example, using meconium instead of urine or blood as the testing medium,[16] will offer a longer timeline of drug use for us to examine. The question which must engage Congress today, however, is this:

> Is new federal legislation required to promote the use of drug tests as evidence of substance abuse?

The answer to that must be a resounding, "No." Nothing in PL 96-272 restricts the use of positive drug tests as indicia or evidence of drug use. Drug tests are one kind of evidence of drug use, (there are many other kinds of evidence, including a newborn's physical symptoms and condition, the testimony of witnesses who observed parental drug use, and a parent's prior court involvements in which substance use was a factor); and a positive drug test may be one factor among many that persuades a judge that there has been neglect or abuse.[17] Most state laws would permit the full development of any kind of evidence bearing on the issue of neglect or abuse, either as a basis for reporting or, within the parameters of the rules of evidence, as a part of the prosecution's case.

California has chosen to amend its reporting laws, but that amendment, emphasizes the minor place of drug testing in the community's assessment of neglect and abuse. In fact the California law is completely congruent with the philosophy of PL 96-272: it advocates reasonable efforts to provide services to families, while assuring protection of the child. Drug testing enhances, rather than stands in the place of, investigation and services. We conclude that this is a strong basis for reporting laws.

3. Removing children from their homes and terminating parental rights

Perhaps no subject is so charged with emotion as the decision to remove children from their homes, whether it occurs early in a case as a protective measure, or later, when the decision to terminate parental rights is being made. Indeed, a pattern of precipitous removal of children was one of the motivations for Congress to enact the "reasonable efforts" provision of PL 96-272. The current substance abuse crisis with its high proportion of abandoned babies and low availability of appropriate drug treatment has child welfare administrators and lawmakers wondering whether fast-track, out-of-home placements should not become the norm again. A few states have amended their neglect and abuse and termination of parental rights laws to make early removals easier.

Today we inquire whether such amendments are necessary on a national scale. Are the "reasonable efforts" provisions in PL 96-272 a barrier to effective protection of the child from imminent danger at home? Or, is it possible that incidents of child fatalities, and patterns of failed parental drug treatment (which tend to extend the amount of time that children are in foster care find their root causes not in the law but in the inadequate implementation of the law? What are the pitfalls in creating a federal model for quick removal of children from the homes of substance-abusing parents?

When one looks hard at the "reasonable efforts" language of PL 96-272, it is clear that nothing precludes a social worker from immediately removing a child from a dangerous home. Protection of the child is the crux of the law. Services need be provided to the family before removal only if the child will be safe in the home during that time. Despite the fact that the law presents no barrier to immediate removal of a child in danger, there continue to be children dying in dangerous homes even after there has been an initial report, and an investigation by the child welfare agency. Why? It is instructive that in Rhode Island during the past year four child fatalities were investigated by the state's Child Advocate.[18] In each family a substance abuse problem was revealed. In each case the Child Advocate found a flaw in the bureaucratic response to the case, usually inadequate training of the social worker or other professional to identify a child at risk and properly respond to that child's need. No problem with the underlying law was discovered.

Making an informed judgment about risk to the child and the needs of a family requires training, adequate resources, an administration that permits swift responses, and cooperative working arrangements among health, law enforcement, and child welfare agencies. Those ingredients of wise decision-making are the same, whatever the law may say, because they are dictated by the exigencies of the crisis itself. When a child is in trouble, whether the cause of family dysfunction is substance abuse or some other factor, the investigating social worker needs training in identifying the problem with the use of a good-risk assessment tool. Then she needs to know which other people must be contacted immediately (e.g. relatives, a law enforcement officer, a homebuilder, an ambulance crew) and she needs the support of her office to accomplish that.

When the case comes to court, the judge needs to be able to identify a problem with substance use, to evaluate the risk to the child (based on information received through testimony and evidence) and to know what resources can be made available to the family through court orders.

It is our experience at the Center on Children and the Law that there are serious deficiencies in training all of these people, from social workers through the judiciary. Through various projects we have aimed at closing the gap (training New York and Florida social workers, developing a national curriculum for judges on substance abuse issues). We have identified over and over again the need for agency cooperation, at both the state and local government level.[19] While we have found minor problems in particular state laws, none of these have been engendered by PL 96-272. Our perception is that the basic federal law is strong.

In substance abuse cases the most persistent complaint is that adequate drug-treatment is not available upon demand. This means that many of the delays that occur in making the decision about whether to pursue permanent out-of-home placement relate to the fact that the parents have not completed -- often because they have not yet been able to gain entrance to -- a drug treatment program. A few states are overcoming this resource gap because the are concentrating their efforts on medical intervention. For example, Washington State has generously funded its drug treatment programs: it has residential placements for mothers and their children, and its cases proceed on the basis of cooperation between the homebuilder and the parent, to the enormous benefit of the children.

While some states have amended termination of parental rights acts to provide for fast termination in substance abuse cases,[20] there are real dangers to establishing a federal model for doing so. States have uneven amounts of resources. That means that while State A can make generous services available to the parents as soon as the case comes into their child welfare agency -- and thus can make a solid, early decision about the potential stability of the home -- State B may have no services to offer. State B would then remove the child and rush to termination without ever having attempted to separate the family from poverty and or to have given the parents an opportunity for drug treatment. A state child welfare agency with no resources to offer its clients is perceived as a police agency, whose job is to identify drug users and punish them by taking their children.

In addition, serious delays in termination of parental rights cases often occur because of administrative problems within agencies and courts. These may be due to both lack of personnel and inefficient procedures. With regard to the courts, the problem is particularly acute in many areas because of three simultaneous developments: (1) the increasing numbers of new cases; (2) the increasing difficulty of drug related cases; and (3) the increasing complexity of the court cases themselves, partly as a result of PL 96-272.[21] Thus the primary barriers to timely termination of parental rights are the lack of timely services and the inability of courts and agencies to prepare, present, and decide cases.

It appears to us that the PL 96-272 law is fundamentally a good one. Rather than altering its requirements for substance abuse cases, more patience and resources are necessary to make it work as envisioned. Judges as well as social workers need to be trained to understand how to make accurate risk and needs assessments as part of their "reasonable efforts" to keep families together. Additional assistance is needed for overburdened courts. PL 96-272 itself does not bar early decisions about permanency planning. Indeed, many courts have established fast-tracks for abandoned babies by court rule.[22] With training and intelligent implementation, swift and accurate risk and needs assessments can be accomplished and children can be well cared for as the family struggles, with help, to heal itself. Nothing in the federal law precludes early decisions in intractable cases. Our concerns are to address the real causes of needless delays -- and to ensure that the decisions be thoughtful ones.

In conclusion, the ABA Center on Children and the Law feels an appropriate Congressional response to the current substance abuse crisis would be laws that facilitate funding of drug treatment of pregnant women, mother-child residential living arrangements, early medical-social intervention programs for children and their familis, and intensive home based services programs to provide for a safe transition of families into drug treatment. In addition, it would be helpful to provide federal assistance to help courts address overwhelming case loads and administrative barriers to achieving timely and appropriate permanent homes for children (which have been exacerbated by substance abuse.) We note that a number of bills addressing these issues have been, or are about to be, introduced during this legislative session.

Notes

1. Eg. New York City Family Court experienced a 471% increase in neglect filings between 1984 and 1989, mostly attributable to drugs. See Comm. on Family Court and Family Law and the Comm. on Juv. Justice, The New York Family Court, 44 The Record of the Ass'n of the Bar of the City of New York 865 - 867 (1989).

2. Nat. Black Child Develop. Inst., Parental Drug Abuse and African American Children in Foster Care, A report prepared for the U.S. Dept. of Health and Human Services, Feb 1991.

3. Minn. Stat. 1988 at 262.5561 and .5562.

4. Dr. Lynn Yonekura, Chief of Obstetrics, Harbor-UCLA Medical Center; Dr. Ira J. Chasnoff, Nat. Ass'n for Perinatal Addiction Research and Education, 11 E. Hubbard St., Chicago, Il. 60611.

5. Should the Laws of Washington State be Expanded or Amended to Address the Problem of Substance-Abusing Pregnant Women? A report for the Wash. State Div. of Alcohol and Substance Abuse, prepared by and available from the ABA Center on Children and the Law, 1800 M St. N.W., Wash. D.C. 20036.

6. Maternity Care Access Act of 1989 known as "First Steps". See also the Wash. State. Div. of Alcohol and Substance Abuse Treatment Protocol for Chemical-Using Pregnant Women.

7. One case, that of Jennifer Johnson in Florida, was recently upheld on appeal. Jennifer Johnson v. State, Docket No. 89-1765, Fla. Dist. Ct. App.

8. See for eg. Proficiency Standards for Drug Testing Laboratories, Hearings before a Subcommittee of the Committee on Government Operations, House of Representatives, One Hundredth Congress, First Session, June 10 and 11, 1987. For a critical view of urine testing, see Greenblatt, D., Urine Drug Testing, 23 New Eng. L. Rev. 651 (1988-89).

9. Dubowski, Drug-Use Testing: Scientific Perspectives, 11 Nova L.J. 416, (1987).

10. Chasnoff, Landress & Barrett, The Prevalence of Illicit-Drug-or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida, New Eng. J. Med. 1202 (April 26, 1990).

11. Minn. Stat. 1988 at 626.556, Subdivision 2.

12. Fla. Stat. Ann. sec. 415.503 (Supp. 1988).

13. Ill. Ann. Stat. Ch. 37, sec. 802-3(1).

14. See also Okla. Stat. Ann. tit.10, sec.1101(4) (Supp.1989); Utah Code Ann. sec.79-3b-8(1),(6) (1987).

15. SB 2669, amending the CA Health and Safety Code, section 10900 et seq. by adding new division 9.7 on Perinatal Substance Abuse.

16. Ostrea, A New Method for Rapid Isolation and Detection of Drugs in the Stools Meconium) of Drug-Dependent Infants, 562 Annals N.Y. Acad. Sci.372 (1989).

17. Larsen, Horowitz and Chasnoff, Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure, 18 Pepperdine Law Review 279 (1991).

18. Inquiries to: Office of the Child Advocate, West Exchange Center, 260 West Exchange Street, Providence, R.I. 02903.

19. Drug Exposed Infants and their Families: Coordination Responses of the Legal, Medical and Child Protection Systems, a monograph from the ABA Center on Children and the Law.

20. Hardin, Ten Years Later: Implementation of PL 96-272 by the Courts, in the Adoption Assistance and Child Welfare Acts of 1980 (North American Counsel and Adoptable Children 1990).

21. The State of Florida extensively revised its Termination of Parental Rights law in the last legislative session to permit faster termination where substance abuse is a factor.

22. See supra, note 19.

Acting Chairman DOWNEY. Thank you, Ms. Larsen.

Judge Gray, you mentioned that Public Law 96–272 requires that reasonable efforts be made to prevent foster care placement and to reunify families. You have developed a protocol for implementing reasonable requirements in drug cases, haven't you?

Judge GRAY. Yes.

Acting Chairman DOWNEY. Let me further ask if you could tell us the difference between the protocols that you have for drug cases and nondrug cases—especially when you may not have enough places to put the drug-abusing parents in treatment or if treatment is inadequate?

Judge GRAY. Let me first say that the protocol that I refer to is a protocol that has been developed by the National Council of Juvenile and Family Court Judges.

In response to a statement Ms. Larsen made, that judges do have the need to have training, one of the things that we did in order that the judges might better prepare themselves to deal with these types of cases, the national council did obtain a grant to study the problem with other professionals, doctors, social workers, treatment people, to find out the kinds of things that judges really needed to know in order to make these decisions.

As a part of that process, we developed the protocol that you are talking about, which we hope will be adopted by the national group at our convention in July. We are still developing the protocol, and it is not being implemented at this point by any particular court. After the national organization approves it, then we are hoping to do some pilot projects in some of the States.

Acting Chairman DOWNEY. What is the level of training for judges? What is your particular background and expertise for working in family court?

Judge GRAY. By the time that I ran for the position that I hold, I had been an attorney for 9 years. After graduating from law school, I worked with the Baton Rouge Legal Aid Society, in which I handled domestic cases, which included divorces, separations, and custody issues, and some neglect cases. I worked there and then went to work for the attorney general for the State in the antitrust unit, and obviously that did not give me any particular training in this area.

From there, I worked with the Equal Employment Opportunity Commission as a trial attorney, and one might argue that did not give me any insight, either. I guess I would say that my real advantage and my expertise in this area is from the fact that, during my career, I worked with a lot of programs in the community that work with families and children, in an effort to try to improve the plight of families in our communities and my dedication to the job that I hold.

Acting Chairman DOWNEY. That is not in question here. What concerns me is the allegation that can be made, can it not—if it cannot be, disabuse me of it—that, in many instances, family court judges do not have the sort of background, interest, or expertise that you do. Is there any formal training program that the State of Louisiana has for family court judges?

Judge GRAY. Every State, I believe, has what they call a judicial education committee or council, and periodically they sponsor training programs, seminars, educational programs so that the judges might become aware of various issues.

Now, obviously, that does not mean that the kind of issues that I deal with or that family court judges deal with are going to be a part of the agenda every time, but I do think that in most every State there are efforts made periodically to have judges receive information, have the benefit of current research on the issues that we are talking about.

For the juvenile and family court judges, we have the opportunity to participate at the Judicial Council in Reno periodically, where they do cover issues such as substance abuse, all the issues of termination of parental rights, abandonments, delinquency issues, as well, where we can go periodically to be trained, to get the benefit of research in that area, and I might say that the juvenile and family court judges do participate on a regular basis in those kinds of efforts.

Acting Chairman **DOWNEY**. Tell me a little bit about your caseload. What is a typical day like for you? How many cases will you see?

Judge **GRAY**. Just let me say a little bit about how my docket is set up. I have neglect and abuse, delinquencies, and criminal nonsupport of families, so twice a week I do delinquency cases and on those 2 days I may have an adjudication of a neglect and abuse case.

I have set aside one day of the month where I conduct my periodic reviews under Public Law 96-272. When I first did the 1 day a month, that was sufficient, and now I am finding that I have to go to 2 or 2½ days a month, in order to do my periodic reviews.

I generally will have an adjudication of a neglect and abuse case an average of probably 5 days out of the month, at least one new case, and my reviews generally are from 20 to 30 a month.

Acting Chairman **DOWNEY**. Thank you.

Mr. Shaw.

Mr. **SHAW**. Thank you, Mr. Chairman.

Ms. Larsen, when we were out at Washington General Hospital, we saw a number of youngsters who were not really infants, they were getting up in age, some of them. I know one of them was a cute little kid about 8 months old that stole everybody's heart. Those are kids that really are being left in there too long, they are missing the time when I understand the bonding process is very important. Can you suggest how the law might be changed to take care of those precise situations, without really in any way trampling on the rights of the parents themselves?

Ms. **LARSEN**. Congressman, are you particularly concerned about speedy resolution of the case?

Mr. **SHAW**. Yes.

Ms. **LARSEN**. A number of States have provided for very speedy resolution of abandoned infants through simple changes in court rules. Now, there are unique problems that can exist in a particular State that would actually require a State amendment, and we would urge States to go ahead and make those amendments, but our concern would be the development of a Federal law that required a decision to be made about permanent placement within, say, a radically different time, let us say 30 days or a couple of months, for the reasons that I indicated.

I think that everyone's interest is served by quickly getting abandoned infants into permanent placements. There is a great deal of difficulty in determining what is abandonment, as the judge also would note.

Mr. SHAW. As I recall, and maybe somebody who was there or even staff could correct me on this, I recall that some of the problem was also the caseload here in Washington.

Ms. LARSEN. Now, that is a completely different thing. For example, the Center on Children and the Law was invited to Washington State to interview maybe 50 professionals in all aspects of this problem, to determine whether we should recommend that Washington State change its laws to cope better with drug use in pregnancy. We found that, in King County, Seattle's jurisdiction, by court rule, abandoned infants could be taken care of within 30 days, but they were not being taken care of that quickly, and that was because of court backlogs and because of problems in the child welfare agency.

Mr. SHAW. Isn't it interesting that accused felons have a right to a speedy hearing and a speedy trial, but abandoned children do not?

Ms. LARSEN. That is right, and if I may also point out, there is another area that is critical: that is, bringing these cases into court jurisdiction. A lot of children, for example, in Washington, D.C., are languishing in hospitals prior to ever being reported and brought into the court, because of the caseloads in the child welfare agencies.

Mr. SHAW. Thank you, Mr. Chairman.

Judge GRAY. If I might comment to Mr. Shaw's question, Mr. Chairman?

Mr. SHAW. Surely.

Judge GRAY. Our law in Louisiana allows an abandonment within 4 months. That might seem like a long time, but currently, under the current law, within 4 months, if the child had been abandoned by the parent, they can come into court and that can be declared to be the case and the child can be freed for adoption.

The problem is that because the caseloads are so high of the caseworkers, it is almost impossible for them to get the materials to the legal unit within the office, so that the case can be filed and that it can be heard.

I will tell you that within the court that I sit, we are required also, if an abandonment is filed, we must have a hearing on that case within 60 days, which may seem like a long time, too, but given the fact that we have so many cases, that is not a long time. I can get a case tried in my section usually within 30 to 45 days after it is filed.

Mr. SHAW. I think that is important. I think it is also important to recognize that certainly, as far as trying to save money on caseworkers and what-not and give them such a backlog that they cannot come in and properly evaluate the case, is costing the taxpayers a lot more money in the long run to care for that child during the interim.

From just the standpoint of economics, and certainly for the welfare of the child, it makes sense from every standpoint to put enough people in the system, so that the system can work and these children can be taken care of.

Thank you.

Acting Chairman DOWNEY. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

There is always a danger in this kind of questioning to appear to shoot the messenger, so I want to say before I begin that I am not really interested in that.

Ms. Larsen, I have a hard time listening to your suggestion that what we need are demonstration projects. I would like to hear from you what needs to be demonstrated that has not been demonstrated numerous times already, but, for whatever reason, has not been implemented.

You bring up Washington State and I am very familiar with our problems. I do not think we are any worse or any better than anybody else. I think we are sort of reflective of the national situation. But you must have had some idea, when you recommend demonstration projects, of what kinds of things need to be demonstrated.

Ms. LARSEN. Yes. May I ask whether you are especially focusing on the speedy resolution of abandoned infants?

Mr. MCDERMOTT. I was not specifically focusing on that. I was really focusing on the whole area of child welfare and what happens in the CPS process, so if it is just the court you were talking about—is that what you were saying when you were saying we need demonstrations?

Ms. LARSEN. No, I meant specifically as to shortening the time limits to make a decision about permanent placement for an infant, and the reason that the center staff feels that a demonstration project would be best is that they have recognized that there are a number of issues that could be profoundly affected by very quick decisions, if there are not the resources in the States to implement those decisions.

For example, we have heard earlier testimony that there is an interest in developing kinship care and having families care for children. Well, poor families often do not have the resources to hire an advocate to come into court for them to advocate for their adoption of a related child, and if the State is not so set up that it can offer those resources and that legal protection, they might end up with cross-cultural, cross-economic adoptions that are ultimately discriminatory.

Now, maybe that would not happen, but the concern of the staff that has studied this at the Center on Children and the Law is that we make sure that there are not any of those nightmares that develop out of what appears to be a good motive and we would prefer to see a demonstration project for 1 or 2 years on that narrow issue.

Mr. MCDERMOTT. So, you would envision a grant being given to Orleans Parish for an additional judge and three or four caseworkers and some legal services attorneys to represent people who otherwise would not have an attorney to come in and make their case for them? That is the kind of demonstration you are talking about?

Ms. **Larsen**. That would be the kind of demonstration under the narrow parameters of abandoned infants, for example.

Mr. **McDermott**. Let me ask another question of both of you. People talk about substance abuse here, and I do not know if they are talking about alcohol and other illicit drugs, or are you just talking about cocaine and heroin and so forth? And is there a difference in the way children are treated, depending on which drug their mother happens to be involved with?

Judge **Gray**. When I and the members of the National Council of Juvenile and Family Court Judges talk about substance abuse, we include alcohol and all illicit drugs. The reason for that primarily, I guess, is because most or a lot of substance abusers are polydrug users and the most common second drug is probably alcohol, and so when we talk about substance abuse, we include alcohol.

The question about the children treated differently, do you mean are they treated differently by their parents or by the system, once they come in?

Mr. **McDermott**. By the system. If the mother is picked up, there is a CPS referral because the mother is alcoholic and not taking care of her kids. Does that put her into one stream, as opposed to somebody who is picked up by the police for drug use? Do her children wind up in the same stream? Where are the interfaces between those systems?

Judge **Gray**. At least as it happens in my State and in my community, they are placed in the same stream. The differences probably are that, to the extent there are resources and treatment available, there may be a few more treatment options for alcoholics as opposed to substance abusers, but, by and large, the problem is still the same, that there are not sufficient treatment options for either the alcoholic mom or the cocaine or heroin addicted mom.

The problem for both is that, to the extent treatment is available, it usually means that, in order get the treatment they need, they will have to be separate from their child or children, because there are no treatment centers in Orleans Parish which are geared to treating the mother while she still has custody of her children. She cannot take the children to the treatment center with her, and we see that as a big problem and, when we talk about an array of services, we need to make sure that those kinds of things are available in the community, where mom can get treatment and, if she needs to be in inpatient treatment, that she can still have her children with her, because when we separate them, then we do something to the bond. So, the difference is, to the extent there is a difference, it is based on the treatment options that are available.

Mr. **McDermott**. I see that my red light is on, but let me ask just one question—it is not a short question. You sit on the bench and you are faced with the case where you have a woman in front of you who is in danger of losing her children, but there is not treatment available for her. You know that the slots in the drug treatment program are 6 weeks or 3 months in backup, how do you handle that?

Judge **Gray**. In my view, sadly, what we do out of concern for protection of children, we usually remove the children. However, I recognize that there is substantial harm in that action, in and of itself, it is harmful to children to be separated from their parent, but in trying to weigh the two risks that are present, when I am convinced that there is a substantial risk to the child and there are no services that we can place in the home to protect that child, I only have one other option and that is removal.

Mr. McDermott. I assume the judge's experience in Orleans Parish is comparable to the rest of the United States.

Mr. Larsen. Four-square, across the Nation, everything the judge has said that happens in New Orleans happens in other States.

Mr. McDermott. The same problem of the interface between drug and alcohol?

Ms. Larsen. Correct.

Mr. McDermott. Thank you, Mr. Chairman.

Acting Chairman Downey. Thank you.

Mr. Chandler.

Mr. Chandler. Thank you, Mr. Chairman.

I would like to begin by saying I read your opening statement and I commend you for it, not only for its sensitivity, but I think obviously your understanding of a very complex and extremely difficult issue.

Judge Gray, in response to the question of my colleague from Washington, you convinced me that you know something about this subject when you said you believe that both alcohol and illegal substances are a part of the drug problem, and I very, very much agree with that.

I wonder, have you had any success—and, Ms. Larsen, I would be interested in your view, too—in a technique that has been used oftentimes in criminal cases of diversion from the criminal justice system, with the understanding that certain steps will be taken that perhaps would include treatment, if available, or attendance at AA or NA or both, or perhaps job training or something like that. Have you had the opportunity to try this technique, and what has been your experience with it?

Judge Gray. Well, as a part of all of our cases, a lot of the cases that I deal with come directly to juvenile court, and there is not a diversion from criminal court. There may not ever be a criminal charge against either parent.

As part of the disposition in virtually every case that I handle, if we have a substance abuse problem, the mother is going to be ordered to treatment, she may also be ordered to have drug screenings done on a periodic basis, depending on the level of the education of the mother and, unfortunately, for most of the people that I deal with, it is very low, there may be a part of the order that requires the mother to have a vocational assessment and then also vocational training.

How to evaluate the success rate is very difficult, because once we get involved with the family, we never seem to get uninvolved. Because the drug problem is so severe, if it is a part of the case, it means that it will be a long-term involvement, where we may not see any positives for a very long period of time.

One of the difficulties I think is because of what I have already addressed: I think when you start talking about substance abuse, you need to address the substance abuse problem first. Unfortunately, what we do in most of the cases is require substance abuse treatment, we require the vocational education, we require the parenting classes, we require so many things of the parents that they end up not doing any of it.

So, my view is that we need to first address the substance abuse problem, try to get that under control, and then after that is controlled, some of the other things may be able to be dealt with.

Mr. **CHANDLER**. Does threat of the loss of the child motivate these parents?

Judge **GRAY**. Sometimes yes, sometimes no. I would say the answer to that depends on the severity of the substance abuse problem. Sometimes they are motivated the first time that you talk to them about the risk of losing their kid, other times they are not, and sometimes it takes a short-term removal with a relative, and then the parent will believe that it is serious and then they will begin to take steps to address the problem, but a lot of times they will not respond to that.

Mr. **CHANDLER**. In the case of the teen mother, obviously, you are dealing with a parent who, in many cases, not that long ago was a child herself——

Judge **GRAY**. And still is, sometimes.

Mr. **CHANDLER**. And still is, yes. Well, emotionally, I would say if they are on drugs and alcohol, they still are, regardless of the age.

Judge **GRAY**. Chronologically, some of them are still children.

Mr. **CHANDLER**. For those children, is there a treatment technique or an intervention or something that could be done to break the cycle, to try to see to it that that child does not him or herself become an abusive parent or a teen parent or one who views life without hope? What is your suggestion? How do we get ahead of this?

Judge **GRAY**. That is a very difficult question. I spoke earlier in my comments about what I think are the long-term solutions, and those are education. I think that working with—there are several programs around the country. One that comes to mind is by the National Council of Negro Women, where they work with teenage mothers, they have what they call the teen enlightenment program in the area that I am in, where they bring in teenage mothers, and they are now also bringing in the fathers, to talk to them about positive self-image, how to take care of themselves and to show them the risk that having one, an early pregnancy the first time, but certainly the second pregnancy, what that will mean to both their lives and to the child that they already have, and to try to discourage them from having yet another pregnancy.

I think those kinds of programs are good programs and probably need to be implemented in more cities and funded so that they can include more children in them.

I think that we have to do more in the school system with educating children on these issues early on, so that perhaps we can prevent some of the teenage pregnancies. I think intervention is the key, and we need to do more in that area.

Mr. **CHANDLER**. Mr. Chairman, if I could use up a little red light time here, just to comment. What you said about self-worth I think is right to the mark, and we all know how difficult that is for the most successful of us, let alone somebody who really starts out under considerable hardship.

Some day, if we can bring the committee out to Seattle, I would like to visit the Zion Preparatory School, where they start with 2-year-olds, and the whole notion of that school is to tell children "you can and we expect you to," and the results are absolutely remarkable.

Thank you, Mr. Chairman.

Acting Chairman **DOWNEY**. Judge Gray, in the last 2 years, are the problems of drug abuse and the neglect and abuse of children getting better or worse, in your view?

Judge **GRAY**. Worse.

Acting Chairman **DOWNEY**. Ms. Larsen.

Ms. **LARSEN**. That would be my observation. We have not crested the wave yet. We hear on the criminal side that there are fewer arrests for substance abuse, but in the neglect and abuse area, the substance abuse as a factor continues to rise.

Acting Chairman **DOWNEY**. So, you do not think this is a war we are winning?

Ms. **LARSEN**. No.

Judge **GRAY**. No.

Acting Chairman **DOWNEY**. Thank you very much.

Judge **GRAY**. Thank you, Mr. Chairman.

Ms. **LARSEN**. Thank you.

Acting Chairman **DOWNEY**. We will next hear from a panel comprised of the National Association of Children's Hospitals and Related Institutions, Alice Kitchen is the director of social services at Children's Mercy Hospital, in Kansas City, Mo.; the National Black Child Development Institute, Inc., Clarice Walker, member, board of directors, and Ms. Walker is also a professor of the school of social work at Howard University, here in D.C.; Child Welfare League of America, Inc., Richard L. Jones, Ph.D., chair of the CWLA North American Commission on Chemical Dependency and Child Welfare, and he is the executive director of Boston Children's Services; and the National Council on Alcoholism and Drug Dependence, Inc., Christine Lubinski, director for public policy.

Ms. Kitchen, we would be happy to hear from you first.

STATEMENT OF ALICE KITCHEN, DIRECTOR OF SOCIAL SERVICES, CHILDREN'S MERCY HOSPITAL, KANSAS CITY, MO., ON BEHALF OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC.

Ms. **KITCHEN**. Mr. Chairman and members of the subcommittee, I am Alice Kitchen, director of social services at Children's Mercy Hospital, in Kansas City.

Thank you very much for the opportunity to testify on behalf of Children's Hospitals. I will submit my testimony for the record.

I want to cover two things for you in my testimony. I will tell you about the nature of the problem of the infant born to substance-abusing parents, the ones that we are seeing in Kansas City, and I want to tell you about the response that we are developing in our community, through the hard work and cooperation of many different agencies, and because of public and private resources that we have received.

Children's Mercy is a pediatric, private, nonprofit hospital that works closely with our public hospital, Truman Medical Center, in Kansas City, to meet the health care needs of low-income families.

Two years ago, our hospital and our local child protection agency organized a Metropolitan Task Force on Drug-Exposed Infants. Our task force has identified many alarming indicators of the scope and size of the problem. We have identified six findings:

First, the number of infants born drug-exposed is growing rapidly. In one hospital alone, our public hospital every month, 30 additional infants are born drug-exposed. We are now seeing the second child born to some of these drug-addicted mothers.

Second, hospital care for drug-exposed infants can be very expensive. High-risk, premature drug-exposed infants are more likely to come to our neonatal intensive care unit. These babies spend an average of 44 days in the hospital, at a cost of $1,000 to $1,500 per day. That is twice as long as the average length of stay for a premature infant who had not been drug-exposed.

Third, the Missouri Child Protection Agency has seen an alarming growth in the number of families that are under their protective supervision, and it is mostly due to the crack epidemic. During the past 3 years, the State agency in Kansas City has experienced a 50 percent increase in the number of families under their supervision. Last year alone, 100 new children came into our child protection service.

Fourth, a host of serious problems are more commonplace among these families where drugs are the primary substance abuse. We see more children abandoned in these families, they are left unattended, they lack followup medical care, their lifestyles are chaotic, these infants are medically fragile, with many social and medical complications. Often, there is violence and crime activities related in these families where drugs are abused.

Fifth, the disparate needs of these families stretch an already overworked social service system. Caseworkers' workloads already are at the breaking point. Their time is tight, they lack training in either drug or alcohol intervention. Too often, services that the families need are simply not available, not reimbursed or without child care, cannot be availed.

Sixth, even with additional hard work, cooperation, and additional resources, we are able to reach only a handful of the children and the families in need. Only 1 out of 4 drug-affected infants from our public hospital is enrolled in our comprehensive community-based program.

Now, I want to tell you about how we are trying to make our social service system work better for these children and their families. Among the two most important innovative components of our response are our linkage coordinator and our new Federal grant to prevent abandoned infants.

The linkage coordinator works with Federal, State, local, and private support. We have established a linkage coordinator. She is a juvenile court employee who works between the different agencies, to make them work together for the benefit of the infant and the child and their family. She has the authority of the court behind her to problem-solve, to break down barriers to services, to generate additional resources that can keep this family together, and she has the ability to encourage medical and protective followup for the newborn.

Our linkage coordinator, who we affectionately call our "head nag," has the ability to forge cooperation between agencies in such a way that we are seeing new trends and new cooperation.

The second program we are very proud to call and have in effect is the TIES program. It stands for Teams for Infants Endangered by Substance Abuse. This program grew out of the efforts of our task force and was funded as a demonstration grant under the Federal Abandoned Infants Assistance Act.

This grant provides a comprehensive case management system for 40 families with drug-affected infants. Our program involves 8 community-based agencies, representing home health, day treatment, child care for medically fragile children, two hospitals, our court system, and our State child welfare agencies.

TIES provides prenatal case management and outreach, serving a minimum of 90 families in the community. We have a foster care recruiter working in our black community and through our local churches. We have a developmental and medical followup clinic and training for all of our staff of the different programs.

Since 1989, our hospital has had a clinic for these families. Through this experience with 30 infants and families, we learned what was needed and how serious this problem is. Now, with our TIES program, we have 19 families who have volunteered to have a case manager work closely with them in the community. Eight of these mothers are now in treatment, all but one of the newborns have been in for scheduled medical appointments, no rehospitalizations have been required, and all but one of the newborns stayed in the custody of their mothers.

In conclusion, I want to emphasize two points: The programs that I have described do work, they are helping keep families together, provide safety and health care for the newborn and save money in the long run, but, in the short run, we still only have the resources to reach one-fourth of the drug-exposed babies in our one public hospital.

At the local, State, and Federal level, we must invest more in training, link the existing resources that we do have, increase our resources to meet growing needs, and give more flexible discretionary dollars to social service providers to secure appropriate resources and, beyond all of this, we must invest in drug-free environments for these families and, of course, prevention.

That concludes my statement.

[The prepared statement follows:]

"Impact of Substance Abuse on State and Local Child Welfare Systems"

Testimony by

Alice Kitchen
Children's Mercy Hospital
Kansas City, MO

Ways and Means Subcommittee on Human Resources
U.S. House of Representatives
Washington, DC

April 30, 1991

Mr. Chairman and members of the subcommittee, I am Alice Kitchen, Director of Social Services for Children's Mercy Hospital in Kansas City, MO. Thank you for the opportunity to testify before you on behalf of NACHRI -- the National Association of Children's Hospitals and Related Institutions. I serve as a member of NACHRI's Advisory Group on Children of Substance Abuse, on which I am working with representatives of children's hospitals across the country to examine the size and scope of the problem posed by drug-affected infants to their families, communities, and our hospitals.

NACHRI is the only national voluntary association of children's hospitals in the United States. It represents more than 100 member institutions, including Children's Mercy Hospital. Virtually all of the children's hospitals among NACHRI's member institutions are teaching hospitals, and many serve as regional medical centers. They care for very sick children, children with very specialized health care needs, and children of families with very low incomes.

NACHRI Survey

Last year, in response to reports of the increasing incidence of children born to substance abusing parents, NACHRI conducted an informal telephone survey of 18 children's hospitals to assess their experience with the care of infants who were perinatally exposed to maternal substance abuse. Our phone survey indicated that both freestanding and non-freestanding children's hospitals, in urban as well as wider metropolitan areas, are seeing a growing number of cases of drug-exposed infants, the majority of whom have been exposed to cocaine, crack, and alcohol.

These infants have multiple, complex medical and psycho-social problems, which require multi-disciplinary, resource-intensive care, often including neonatal intensive care, due to the infants' extreme prematurity and low birth weights. While they have difficulty relating specific clinical problems and the costs of care to drug exposure versus prematurity and low birth weight, the hospitals acknowledge that the combination of drug-related birth defects, low birth weight, and prematurity results in even more complex medical problems, more intensive clinical needs, and higher costs of care. Most often, the costs of hospital care for these children are paid by a combination of Medicaid and other state special funds, or they are uncompensated.

NACHRI's survey suggests that systems are not currently in place and adequate resources are not being made available today to meet the needs of this growing patient population. According to NACHRI's phone survey, the family needs of drug-exposed infants are very complex and require intensive interventions by hospital social work staff. For example, according to the responding hospitals, virtually all of the drug-exposed infants stay beyond their medically ready discharge dates. Unnecessary stays may range in length from one day to several months. Several hospitals cited the lack of appropriate foster care as the reason for the delayed discharges.

As a result of this survey, NACHRI has initiated educational programs for its member hospitals, organized the advisory group on which I serve, and begun to develop a more sophisticated survey instrument to use in documenting more precisely the experience of member hospitals in the association.

Children's Mercy Hospital

The experience of Children's Mercy Hospital is consistent with the findings of NACHRI's survey. In Kansas City, the drug epidemic has caused an overloading of our child welfare system. Substance abuse has added complexity to the work of child welfare and health care providers, whose previous training has not been adequate to meet the needs of the families of substance-exposed infants. Treatment resources for these families need to be increased along with funding for aggressive outreach programs.

The Kansas City Experience In 1989, Children's Mercy Hospital and the local child protection agency convened the Metropolitan Task Force on Drug Exposed Infants, working with local health care providers, social workers, and legal specialists at the frontline of service delivery. As a result of the efforts of the Task Force and Children's Mercy Hospital, we can identify a number of indicators of the magnitude of the problem.

- Approximately 30 infants are born drug-exposed **per month** in Truman Medical Center, the adult public hospital in Kansas City, according to drug screen results. (This means a positive drug screen for drug use by the pregnant woman during the previous 72 hours.)

- High risk, premature drug-exposed infants are more likely to come to Children's Mercy's Neonatal Intensive Care Nursery. Their hospitalization averages 44 days compared to 22 days for non-drug exposed premature infants. (The cost of hospital care alone -- not including physician care -- for a premature infant ranges between $1,000 to $1,500 per day.)

- The mothers of these infants tend to be in their mid-to-late 20s, with two or three other children. They have no job, and their average education level is 10th grade. However, previously they have functioned well, and the birth of their drug-exposed infant has led to their first involvement with the child welfare system. The use of drugs is the key factor in the disintegration of their families, with the families needing both substance abuse assessment and treatment.

- The Missouri child protection agency -- the Division of Family Services -- has experienced a 50% increase in the number of families under their supervision during the past three years. In the last year alone 100 new children have come into the child protection system, most of them due to the crack epidemic.

- About 80% of all families currently hotlined to the Missouri Division of Family Services and 50% of those supervised by the division have significant drug or alcohol problems.

- Abandonment of children, leaving children unattended, and lack of follow-up medical care are more commonplace in families where drugs are the primary substance abused -- because of chaotic family lifestyles, parents with a history of sexual and child abuse, medically fragile infants with physical and developmental complications, and violence and crime related activities found in homes with drugs, particularly cocaine.

- The incidence of substance abuse-exposed infants among black children has increased and there is now a disproportionate need for minority foster care families. About 60% of children in foster care are black; 40% of foster care parents are black.

As these facts suggest, the children of substance abusing parents and their families pose enormous challenges to foster care, child protection, and social service programs whose staffs already have large caseloads, limited time, and no training in drug or alcohol interventions. Nor do these professionals necessarily have training to understand childhood developmental milestones, growth charts, and the dynamics of the addiction process. They need training to gain skills in intervening with families to reduce barriers to cooperation and to carry out in-home assessments that require skills in recognizing the environmental impact on newborn and siblings, as well as maintaining cultural sensitivity.

The challenges of meeting the social service needs of the families of drug-exposed infants are especially obvious in comparison to the needs and circumstances of alcohol abusing parents. Today, more of the women we see are poly-drug users. Those women who use crack cocaine are more likely to be addicted than purely recreational drug users. Along with the use of crack cocaine we see major psycho-social problems, domestic violence, legal entanglements, sexually transmitted disease, and prostitution.

This social disruption to the family is not as evident in the women who are primarily alcohol users or abusers. Violence and crime are more frequently associated with drug abuse. The effects of alcohol used during pregnancy are difficult to diagnose in the perinatal stage unless the damage is significant enough to cause visible facial and other symptomatic features called fetal alcohol syndrome. However, alcohol is more widely used than drugs and just as damaging to the fetus.

While we do not have tests that can be easily administered for alcohol abuse and exposure, urine drug screens in the mother or infant can alert the medical team to watch for and continually test for symptoms in infants associated with perinatal drug exposure: irritability, lethargy, poor feeding, weight loss, wakefulness, hyperactivity, and difficulty being comforted. Many drug-exposed infants are born prematurely with complications including low birth weight, low oxygen (asphyxia), central nervous system problems, disruption of growing tissue, growth retardation, small head size, and the potential for mental retardation.

Because of these medical complications, drug-exposed infants require more care and do not respond as do other infants. That increases their risk for child abuse, neglect, and endangerment, which may also be exacerbated if the mothers experience drug-induced mental disorders (i.e., psychosis).

In sum, the children of substance abusing mothers are growing in number in our community. They and their families need special help and interventions which are not the same needs of families of ten and 20 years ago. The children's medical complications add further stress to the family, which requires technical knowledge and training to treat. These families need in-home services which are often not available or reimbursed. For example, the State of Missouri does not automatically accept referrals for child protection services when drug exposure is the only presenting problem. This results in necessary social services as well as health care not being immediately available.

The Kansas City Response As a result of the work of the Metropolitan Task Force on Drug Exposed Infants, we have undertaken several steps to respond to the growing and new demands on social services.

- **Linkage Coordinator** With federal, state, local, and private support, we have established a "Linkage Coordinator" who works between agencies on behalf of the infant and family. Better known as the "head nag," the Linkage Coordinator is a Jackson County Juvenile Court employee who, with the authority of the court behind her, has the job to problem solve, break down barriers to services and resources that will keep the family together, and ensure both protection and medical follow-up for the newborn.

Under the supervision of myself and my counterpart at Medical Truman Center, the Linkage Coordinator works with our child protection agency, juvenile court, two hospitals, and home health agency. One of the vital roles of the Coordinator is to staff "High Risk Case Conferences" in which frontline workers and appropriate staff members come together to discuss problems identified by the staff. Because of the uniqueness of this position, the Linkage Coordinator has been able to secure services for families, forge cooperation between agencies, and obtain resources in ways that we have not experienced in the past.

- **Family Aide Program** With funding from a March of Dimes grant, we have been able to secure during the past four months "in-home" aides to provide "hands-on" support for the mothers. Through this Family Aide Program, a family aide goes to the home to give tangible support to the family, while also serving as a role model and giving parent education. This program complements the work of our Linkage Coordinator as well as the case managers in our comprehensive case management program (TIES -- see next page).

- **Comprehensive Substance Treatment and Rehabilitation Progam (C-STAR)** One of our Task Force's recommendations was to increase the number of substance abuse treatment slots available to pregnant and post-partum women and their children. It is very difficult just to persuade the woman to agree to enter treatment. However, even when a woman agrees to treatment, there may be no treatment program available to accept her. And even if there is an available treatment program, lack of child care may prevent her from participating in treatment.

Missouri's Department of Mental Health Division of Alcohol and Drug Abuse recognized the need, listened to our recommendations, and implemented the C-STAR Program. It enhances existing services with the addition of case management, day treatment, drug-free environments, residential facilities, and counseling programs. C-STAR emphasizes treatment to the mother and child, bonding, and good health habits. Medicaid coverage has been integrated into the program.

- **Teams for Infants Endangered by Subtance abuse (TIES)** Last fall, we received a three year federal grant under the Abandoned Infants Assistance Act, administered by the U.S. Department of Health and Human Services' Administration on Children, Youth and Families. The grant provides for comprehensive case management for 30 families with drug-affected infants, prenatal case management and outreach serving a minimum of 90 families, foster care recruitment in the minority community, developmental and medical follow-up, and training for child welfare, health care, foster care, child care, and court staff. (These families are in addition to the 30 families with whom the hospital's Special Assessment Follow-up Clinic has worked over the past 18 months.)

Eight community-based agencies belong to the TIES consortium. We meet monthly to design, refine, and guide the program implementation. These agencies represent home health, day treatment, child care for medically fragile children, two hospitals, the court, and our child welfare agency.

To date, 19 families have volunteered to have case managers under TIES work closely with them. One of the major tasks of the case managers is to confront constructively the mother's denial and to encourage her to view more realistically the effects of her drug use on herself and her family. Eight are now in treatment; for all but one this is their first involvement with treatment. All but one of the newborns have been scheduled for appointments. No re-hospitalizations have been required, and no infants have been removed from the custody of their mothers after their discharge from the hospital.

However, due to resource limitations, only one in four drug-affected infants from our public county hospital is enrolled in our program. TIES has consciously kept the caseload sizes limited to address needs immediately, and to respond to each family individually.

Conclusion

In Kansas City, we have been extremely fortunate to have had the strong cooperation and resources of so many health, social service, and judicial leaders as well as public and private institutions in responding to the crisis of infants born to substance abusing parents. However, other parts of Missouri and Kansas are not so fortunate, and even within Kansas City, we still have the resources to meet the needs of only a fraction of the children and their families.

At the local, state, and federal levels, we need to:

- invest more in training,
- invest more in comprehensive program coordination,
- increase our resources to meet the growing needs for services, and
- give greater flexibility to social service providers in the use of discretionary dollars to meet the needs of individual families.

And beyond all this, we must invest in drug free environments for these families and, of course, prevention.

Mr. Chairman, this concludes my statement. I would be happy to try to respond to any questions the subcommittee might have.

Acting Chairman Downey. Thank you, Ms. Kitchen.
Ms. Walker.

STATEMENT OF CLARICE D. WALKER, VICE PRESIDENT, NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE, INC., AND PROFESSOR, SCHOOL OF SOCIAL WORK, HOWARD UNIVERSITY, WASHINGTON, D.C.

Ms. Walker. Thank you, Mr. Chairman and members of the subcommittee. We appreciate your invitation to testify today.

I am Clarice Dibble Walker, a professor of social work at Howard University. I come before you today as vice president of the National Black Child Development Institute, and as principal investigator of two studies undertaken by our organization on African-American children in foster care.

My comments today are based on these findings.

Our findings cause us grave concern, and we appreciate this opportunity to discuss the impact of parental substance abuse on the child welfare system with you.

For more than 20 years, NBCDI and its local affiliates across the country have been engaged in the ongoing struggle to reform and strengthen child welfare systems that have historically served our children and their families, not very well.

Our concern has been with the disproportionate numbers of African-American children in foster care nationally. The latest available data on the percentage of African-American children in foster care showed that 37 percent of the total number of children in foster care in fiscal year 1987 were African-American, according to the APWA. Comparatively, African-American children comprised only 13.8 percent of the total population of children under 18 for 1987.

From our findings, it is apparent that: First, parental substance abuse is having a dramatic impact on the national foster care caseload; second, children are not achieving permanency in the child welfare system, despite the mandated goals and guidelines encompassed in the Adoption Assistance and Child Welfare Act of 1980; third, prevention and early intervention programs targeted to families at risk of foster care already involved with parental substance abuse need to be initiated and expanded, in order to reduce the number of children entering foster care; fourth, relatives of children who are in foster care are available in many cases to provide assistance in caring for children. However, frequently they need support and family support services to assist them in their caretaking roles; fifth, services to address the problems contributing to foster care placement are insufficient and are not well-coordinated, keeping children in care for unnecessarily long periods of time, and separated from their families; and sixth, substantial changes in the way services are organized and resources are allocated at the local, State and National levels are required in order to provide the types of comprehensive services necessary for a family's reunification.

Now, these conclusions were reached as a result of a 2½ year study by NBCDI of 1,003 African-American children placed in foster care in 1986. The children studied were from five cities, New

York, Miami, Detroit, Seattle, and Houston. Their foster care case records were the source of data.

The study examined the characteristics of the children and their families before placement, the reasons for placement, the services offered by the agencies, the role of relatives in foster care, and the number and timing of discharges, as well as other outcome measures.

We compared the children who came into foster care because of parental drug abuse with those who came into care for other reasons. We also analyzed more recent data from New York on the children's discharge status as of late 1990.

Our research came about 1 year after crack cocaine was known to be available in our Nation's major cities. By 1986, which was the year of the study, at least the year that the children came into foster care, its effect were already being felt in child welfare agencies: 36 percent of the studied children came into care because of reported parental substance abuse, among other factors.

In New York and Miami, the figures were much higher, 52 percent and 50 percent, respectively. Of the parents of children coming into foster care reported as substance abusers, crack cocaine was identified as the primary drug use of parents in these two cities. However, I must say that these findings, of course, suggest that polydrug use is also a problem.

Parental substance abuse has led to a dramatic increase in the national foster care caseload in recent years. Drug abuse was also reported as the dominant characteristic in child protective services caseloads in 22 States and the District of Columbia.

Findings from our studies revealed that the problems of poverty, inadequate housing, lack of employment, and substance abuse are interrelated, and it is difficult to isolate one problem from all others.

Families with parental drug abuse had more incidence of poverty and more inadequate housing than the other families with children in care. It must be noted that 67 percent of the mothers from the drug-abusing families had not completed high school, 53 percent were single parents, and 85 percent received AFDC. Inadequate housing and poverty were placement factors cited twice as often among these cases than for the families without drug-abusing parents.

Among the most commonly reported reasons for foster care for the children of parental substance abuses were the physical neglect and lack of supervision of the child, the drug abuse of the parents, the family's poverty, and their inadequate housing.

Among the most commonly reported barriers to reuniting children with their parents was the continued drug abuse by the parent. Drug abuse of the parent prevented reunification in 63 percent of the parental drug abuse cases that were not discharged by the end of the study. Yet, drug or treatment referrals were made by the agency to only 60 percent of all drug-abusing parents at some time during the study period of 26 months. It is likely that even fewer actually received the services to which they were referred.

From evidence available to us, the availability of drug treatment programs was very limited and not adequate to provide mothers with the treatment they needed. Also, many of the treatment slots available in a city may not have been suitable for them.

For example, New York's Mayor Dinkins, in 1990, reported that there is only one residential treatment program in that city which served young mothers with their children. Half of the programs did not accept pregnant women, only one-third treated pregnant women with Medicaid, and only 13 percent provided detoxification from crack for pregnant women with Medicaid.

Again, children are not achieving permanency in the child welfare system, despite the mandated goals of Public Law 96-272. African-American children, like other children, should not remain in temporary care for these lengthy periods of time. It was concluded by Federal statute 10 years ago that children should be moved into a situation of permanency as quickly as possible, whether by returning them to their homes, to the care of relatives, or freeing them for adoption.

The psychological and emotional harm of prolonged stays in foster care have been well documented. Children have only one childhood. If that childhood consists of regular, constant, reliable relationships, it is likely that the child will develop a sense of belonging, a necessary ingredient for good citizenship as an adult. If those conditions do not exist, the future is questionable.

There is growing evidence that children of substance abusers in foster care have not had this opportunity and have experienced interruptions in the bonding and attachment process. Many of the children of substance abusers entered foster care at a very young age, and 50 percent of our study population were under the age of 4.7 years. This characteristic of this population portends serious problems, unless special attention is given to the needs of these at-risk children and their families.

It is indisputable that not every child can be reunited with biological parents. The study's findings show, however, that only 9 percent of the total sampled children of drug-abusing parents were adopted within 26 months after placement, and only 17 of the New York sample's 226 children had been adopted after 54 months in foster care.

We are concerned that child welfare agencies appear to continue to have difficulty in achieving adoption for African-American children, and particularly for those children with emotional, physical and behavioral problems.

I will quickly move to considering relatives, because we think that is an important issue. Relatives of children who are in foster care are available in many cases to provide assistance in caring for children. However, frequently, they need financial support and family support services to assist them in their caretaking role.

Critics question whether any foster care payment should be made to relatives. They fear disincentives for reunification with biological parents, given a presently higher reimbursement for foster care than is the payment level for children under AFDC. The argument goes that drug-abusing parents would relinquish their children to grandparents or aunts, for the sake of added income in the kinship network.

In our study, we found that relatives were an important resource to the children and to the foster care agencies. They obviously sincerely care about the welfare of their grandchildren, nieces and nephews, before any offers of foster payments were even considered.

I would just quickly sum up by saying that the services to address the problems contributing to placement are insufficient and not well coordinated, keeping children in care for unnecessarily long periods of time, and substantial changes in the way services and resources are made at the local, State and national levels are required, in order to provide the types of comprehensive services that are necessary for family reunification.

Finally, we urge that you devote resources to prevention programs, early intervention and coordinate services to parents and children at risk. We urge that you invest in research to improve treatment modalities for substance-abusing pregnant women and parents with child-caring responsibility.

We urge the establishment of comprehensive drug treatment programs for parents which impact the range of services needed by them and are accessible to them. We urge the establishment of training programs for social workers, foster parents, and other professionals who are involved in the protection of children who have been endangered by parental substance abuse.

Finally, we urge the implementation of effective family preservation programs in every community, and particularly in communities which serve African-American children. This commitment must be made, if we are going to prevent the rising tide of damage to these children with subsequent entry into the foster care system, and little hope of reunification with their own families.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF CLARICE D. WALKER, VICE PRESIDENT NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE, INC.

Thank you Acting Chairman, Congressman Downey, and members of the Subcommittee on Human Resources for your invitation to testify today.

I am Clarice Dibble Walker, a professor of social work at Howard University. I come before you today as Vice President of the National Black Child Development Institute (NBCDI), and as Principal Investigator of two studies undertaken by our organization on African American children in foster care. My comments today are based on the findings of these studies and my knowledge of the field. Our findings cause us grave concern and we appreciate this opportunity to discuss the impact of parental substance abuse on the child welfare system with you.

For more than twenty years, NBCDI and its local affiliates across the nation have been engaged in the ongoing struggle to reform and strengthen a child welfare system that has historically ill served our children and their families.

Our concern has always been with the disproportionate numbers of African American children in foster care nationally. The latest available data on the percentage of African American children in foster care show that 37 percent of the total number of children in foster care in FY 1987 were African American (American Public Welfare Association). Comparatively, African American children comprised only 13.8 percent of the total population of children under 18 for 1987 (Census Bureau).

RESEARCH FINDINGS

From our research it is apparent that:

- o Parental substance abuse is having a dramatic impact on the national foster care caseload.
- o Children are not achieving permanency in the child welfare system despite the mandated goals and guidelines encompassed in the Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272.
- o Prevention and early intervention programs targeted to families at risk of foster care or already involved with parental substance abuse need to be initiated and expanded in order to reduce the number of children entering foster care.
- o Relatives of children who are in foster care are available in many cases to provide assistance in caring for children. However, frequently, they need financial support and family support services to assist them in their caretaking roles.
- o Services to address the problems contributing to foster care placement are insufficient and are not well coordinated, keeping children in care for unnecessarily long periods of time, separated from their families.
- o Substantial changes in the way services are organized and resources are allocated at the local, state, and national levels are required in order to provide the types of comprehensive services necessary for a family's reunification.

These conclusions were reached as a result of a two-and-one-half year study by NBCDI of 1,003 African American children placed in foster care in 1986. Our first effort and report, entitled Who Will Care When Parents Can't?, was funded by the Skillman Foundation. A follow-up analysis, Parental Drug Abuse and African American Children in Foster Care: Issues and Study Findings, was performed under contract by the U.S. Department of Health and Human Services. The children studied were from five cities: New York, Miami, Detroit, Seattle, and Houston. Their foster care case records were the source of data. The study examined: the characteristics of the children and their families before placement, the reasons for placement, the services offered by the agencies, the role of relatives in foster care, and the number and timing of discharges, as well as other outcome measures.

We compared the children who came into foster care because of parental drug abuse with those who came into care for other reasons. We also analyzed more recent data from New York on the children's discharge status as of late 1990.

Parental Substance Abuse is having a dramatic impact on the national foster care caseload

Our research came about one year after crack cocaine was known to be available in our nation's major cities. By 1986, its effects were already being felt in child welfare agencies, as our study shows. Thirty-six percent of the study's children came into care because of reported parental substance abuse, among other factors. In New York and Miami the figures were much higher - 52 percent and 50 percent, respectively, of the parents of children coming into foster care were reported as substance abusers. Crack cocaine was identified as the primary drug of use for parents in these two cities.

Parental substance abuse has led to a dramatic increase in the national foster care caseload in recent years. Drug abuse was also reported as the dominant characteristic in Child Protective Services caseloads in 22 states and the District of Columbia (National Committee for Prevention of Child Abuse, 1990).

Child welfare agencies were generally unprepared to handle the rapid growth in caseloads due to parental substance abuse, and were overburdened and understaffed. A good deal of effort was spent by agencies in finding enough qualified foster parents. In many cities, caseworkers carry caseloads many times larger than the national standards of 20-30 children, and often reach 60-70 children (Select Committee on Children Youth and Families, 1990).

Findings from our studies reveal that the problems of poverty. inadequate housing, lack of employment and substance abuse are interrelated and it is difficult to isolate one problem from all others.

Families with parental drug use had more incidence of poverty and more inadequate housing than the other families with children in care. It must be noted that sixty-seven percent of the mothers from the drug abusing families had not completed high school. Fifty-three percent were single parents. Eighty-five percent received AFDC (Aid to Families with Dependent Children). Inadequate housing and poverty were placement factors cited twice as often among these cases, than for the families without drug-abusing parents.

Among the most commonly reported reasons for foster care for the children of parental substance abusers were: the physical neglect and lack of supervision of the child, the drug abuse of the parent, the family's poverty, and their inadequate housing.

Among the most commonly reported barriers to reuniting children with their parents was the continued drug abuse by the parent. Drug abuse of the parent prevented reunification in 63 percent of the parental drug abuse cases that were not discharged by the end of the study. Yet drug treatment referrals were made by the agency to only 60 percent of all drug-abusing parents at some time during the study period of 26 months. It is likely that even fewer actually received the services to which they were referred.

From evidence available to us, the availability of drug treatment programs was very limited and not adequate to provide mothers with the treatment they needed. Also, many of the treatment slots available in a city may not have been suitable for them. For example, New York Mayor Dinkins in 1990 reported that there is only one residential drug treatment program in that city which served young mothers with their children. Half of the programs did not accept pregnant women; only one-third treated pregnant women with Medicaid; and only 13 percent provided detoxification from crack for pregnant women with Medicaid.

Children are not achieving permanency in the child welfare system despite the mandated goals and guidelines encompassed in the Adoption and Assistance and Child Welfare Act of 1980, Public Law 96-272.

Despite mandated P.L. 96-272 goals and guidelines, long-term foster care appeared common among African American children placed in foster care in 1986. This was particularly true of children from families with drug abusing parents. Even after 26 months, 72 percent of the children of substance abusers in the total sample were still in foster care. By contrast, 49 percent of the children whose parents did not abuse drugs were still in care. Reunification with the biological parent was almost twice as frequent for non-parental drug abuse cases as for parental drug abuse cases. Adoptions, guardianships, and other non-reunification discharge options were rare in general for cases with parental drug abuse. However, children from families with parental drug abuse had more frequent placements with relatives.

Other research has demonstrated that there is a declining probability of reunification of children with biological parents over time. The results of our study's examination of New York case discharge records in late 1990 - four-and-one-half years after placement - were thus very disturbing. More than half of these children had never been discharged. Fully 63 percent of children whose parents had been drug abusers were still in care. Their chances for reunification with biological parents are undoubtedly poor.

African American children, like other children, should not remain in "temporary" care for these lengthy periods of time. It was concluded by federal statute ten years ago that children should be moved into a situation of permanency as quickly as possible, whether by returning them to their homes, to the care of relatives, or freeing them for adoption. The psychological and emotional harm of prolonged stays in foster care have been well documented. Children have only one childhood. If that childhood consists of regular, constant, reliable, loving relationships, it is likely that the child will develop a sense of belonging, a necessary ingredient for good citizenship as an adult. If those conditions do not exist, the future is questionable.

There is growing evidence that children of substance abusers in foster care have not had this opportunity and have experienced interruptions in the bonding and attachment process. Many of the children of substance abusers entered foster care at a very young age and 50 percent of our study population were under the age of 4.7 years. This characteristic of this population portends serious problems unless special attention is given to the needs of these at-risk children and their families.

It is indisputable that not every child can be reunited with biological parents. The study's findings show, however, that only 9 percent of the total sample's children of drug-abusing parents were adopted within 26 months after placement; and, only 17 of the New York sample's 226 children had been adopted after 54 months in foster care. We are concerned that child welfare agencies appear to continue to have difficulty in achieving adoption for African American children, and particularly for those children with emotional, physical, or behavioral problems.

A survey by the Child Welfare League Adoption Task Force entitled The State of Adoption in American reported a significant increase in the percent of minority children who are free from adoption, awaiting adoption and yet unadopted. In 1981-82, 37 percent of the "waiting" children were minority. In 1989, minority children represented 51 percent of the population. African American children represent the majority of those minority children who have not been adopted. Barriers to the adoption of these children must continue to be examined. This will be especially important since by all reports, one of the impacts of substance abuse in the child welfare system is that more vulnerable and troubled children are in need of homes.

Prevention and Early Intervention Programs targeted to families at risk of foster care or already involved with parental substance abuse need to be initiated and expanded in order to reduce the number of children entering foster care.

Foster care should be prevented as much as possible by identifying and treating women that can benefit from early intervention programs and prevention programs. Family preservation programs are a better alternative than foster care when families can be helped by these programs.

Relatives of children who are in foster care are available in many cases to provide assistance in caring for children. However, frequently, they need financial support and family support services to assist them in their caretaking roles.

Placement of children with relatives is a care option which is rapidly growing in many jurisdictions in the nation. New York is one example. This option is fueled from two perspectives. Advocates have been persuasive in making the case for the power of the extended family to provide care, continuity, a sense of identity, and belonging to one's family for the child who is being separated from the biological parent. At another level, agencies have experienced severe shortages of family foster parents in recent years and have turned to relatives for needed foster homes.

There is much controversy today over whether or not relatives should be used as foster parents and whether to receive foster care payments or the same types of services or training usually rendered to non-relative foster parents.

Critics question whether any foster care payments should be made to relatives. They fear disincentives for reunification with biological parents given a presently higher (albeit still inadequate) reimbursement for foster care, than is the payment level for children under AFDC. The argument goes that drug-abusing parents would relinquish their children to grandparents or aunts for the sake of added income in the kinship network.

In our study we found that relatives were an important resource to the children and to the foster care agencies. They obviously sincerely cared about the welfare of their grandchildren, nieces and nephews before any offers of foster care payments were even considered.

We found that relatives were able and willing to provide help to the children of substance abusers, usually in the form of a foster placement, 60 percent of the time when the agency considered them. When relatives did not assist, the reason was usually due to a lack of personal financial resources. Foster care payments could remove this obstacle.

Relative placements when appropriate and supported by the agency, promote an uninterrupted relationship for the child with the parent and relative, which is very important to a child's physical, social, emotional, and cultural well being. If agencies encourage strengthened familial bonds, relatives may also continue to function n a beneficial role for the family after reunification.

Services to address the problems contributing to placement are insufficient and not well coordinated, keeping children in care for unnecessarily long periods of time

In addition to continued substance abuse as a barrier to the return of children to the parent, inadequate housing and lack of financial resources were also problems without solutions. According to the case plan, when housing was identified as a problem, the parent was expected to improve the housing conditions, usually an unattainable expectation when combined with the poverty status of the parent. Public housing is usually not a resource with years' long waiting lists, especially in urban areas and no visible coordination between housing authorities and child welfare agencies.

Consider that mothers whose children are in foster care lose their AFDC payments, which for many was their sole source of financial support. Since they may only be employable for menially paid jobs, such parents are more likely to lose or retain their previous housing during the child's placement than being able to upgrade it.

Foster care agencies must depend on public housing agencies to provide housing for the poor. Meanwhile, public housing authorities have waiting lists many years' long in many urban areas.

Even parenting education, a service which is frequently provided directly by the child welfare agency, was offered to only 48 percent of the substance-abusing parents and to 34 percent of the other parents in the study, even though the need was much greater considering that 85 percent of the drug-abusing parents and 70 percent of the non-drug abusing parents abandoned, abused, or neglected their children prior to placement.

Substantial changes in the way services and resources are made at the local, state, and national levels are required in order to provide the types of comprehensive services that are necessary for a family's reunification.

The findings of our research reaffirm the need for major policy changes in child welfare. The system as currently structured and organized is not addressing the magnitude of the child welfare problems associated with maternal drug use. This is illustrated by the sheer increase in the numbers of children, many of them young children, coming into care, particularly in some jurisdictions such as New York, low discharge rates, low rates of reunification with biological parents, low rates of adoption, infrequent parent-child and parent-caseworker visiting, and unavailable reunification services. The infrastructure of services that currently exists is not working effectively for the drug related population. Even the non-drug population seems not be achieving the intents of the foster care reforms embodied in P.L. 96-272. And the numbers of children born exposed to drugs have been growing.

To be effective, the child welfare system will have to be capable of making a serious attempt to answer these parents' multiple problems. Also it will have to have suitable plans for children, if after seriously trying to alleviate parental drug and other problems, it cannot succeed.

We believe that taking punitive legal actions against the mother is not the way to proceed. What is needed is comprehensive services to families that aim to treat all of the family's problems together, preferably under the same roof. As we know, this means dealing with the parental child abuse or neglect, the mother's and the children's psychological needs, the mother's drug problem, the economic problems in the family, and any medical educational, or employment needs that exit. The family's relative support system should be used as an asset during and after foster care.

Substance abusing parents do not have the skills to confer with a multitude of agencies to achieve all of these goals on their own behalf, even with the help of a case manager. They need intensive and personalized services in their home or in the community in order to overcome their many interrelated problems. The threat of losing their children will be a strong motivator for them to succeed.

To make these goals a reality there will have to be far more collaborative efforts on the part of child welfare, health, drug treatment, employment, and housing agencies. Improved programs will need professional representation from all of these fields in order to make them comprehensive for families. This will take major changes in the way these programs and program resources are administered.

Models of such comprehensive programs exist and are said to be successful by their directors and participants. However they are very limited in number and until recently have not been seriously evaluated.

Model programs that have often been described offer a variety of treatment approaches but often share certain basic treatment elements. Programs range from the voluntary to involuntary, from targeting casual to heavily addicted users, from offering outpatient to residential care, from providing home-based to hospital-based centers, and from providing intensive short-term to long-term treatment.

The cost of such comprehensive programs will undoubtedly be great. We believe however that the costs will be greater and we will pay more if we leave children in foster care and abandon their parents to the ravages of drug abuse than by squarely facing the problems. Without an honest remedy to the situation, we can expect to go on paying for drug exposed baby postnatal care in our public hospitals, for special or remedial education for these children and other needed therapies, and possibly for a lifetime of institutional costs such as foster care, criminal justice, homeless shelters, and mental institutions. The costs to society for comprehensive drug treatment and other prevention and education strategies seem to make sense when faced with these alternatives.

Long-term funding for these programs will have to be supported by increased federal spending. Monies from existing funding streams can be coordinated to help support these programs. For instance, medicaid payments must be more in line with the real needs of this population.

CONCLUSION

We have identified the major findings of this report in terms of the needs of children and their families who have been so seriously and tragically impacted by parental substance abuse. It is a crisis for us today and will be a crisis in the future if immediate actions are not taken. Therefore:

We urge the nation to devote resources to prevention programs, early intervention, and co-ordinate services to parents and children at risk.

We urge the nation to invest in research to improve treatment modalities for substance abusing pregnant women and parents with child caring responsibilities.

We urge the establishment of comprehensive drug treatment programs for parents, which affect the range of services needed by them and are accessible to them.

We urge the establishment of training programs for social workers, foster parents and other professionals who are involved in the protection of children who have been endangered by parental substance abuse.

Finally we urge the implementation of effective family preservation programs in every community and particularly in communities which serve African American children. This commitment must be made if we are going to prevent the rising tide of damage to these children with subsequent entry into the foster care system and little hope of reunification with their own families.

Thank you for your attention to this urgent agenda.

Acting Chairman DOWNEY. Thank you, Ms. Walker.

Mr. Jones.

STATEMENT OF RICHARD L. JONES, CHAIR, NORTH AMERICAN COMMISSION ON CHEMICAL DEPENDENCY AND CHILD WELFARE, CHILD WELFARE LEAGUE OF AMERICA, INC., AND EXECUTIVE DIRECTOR, BOSTON CHILDREN'S SERVICES

Mr. JONES. Thank you, Mr. Chairman.

I am Richard Jones, the executive director of Boston Children's Services, and I am representing the Child Welfare League of America. The league is comprised of over 650 public and private child welfare agencies in the United States and also in Canada, and under the auspices of the league, I chair the National Commission on Chemical Dependency and Child Welfare.

What I would like to do in my few moments is to highlight a number of the statistical data that are included in my written testimony.

One, the major conclusion I think that we can all draw from the presentations that were made earlier and also the data that is available, is that substance abuse is having an incredible impact on the lives of children in our world today.

Over 100,000 parents of children who are participating in Head Start programs across the country are chemically dependent. We also know that in any one year, there are as many as 375,000 infants who have been drug exposed. So, the data clearly points out the fact that we are experiencing a major crisis as it relates to the lives of young children.

What tends to happen in the child welfare system is that many of these children are eventually seen in any one of a number of child welfare services today. Child welfare is a system which is designed to protect the welfare of the child, is a system that has broad responsibility for investigating abuse and neglect reports, for making initial custody recommendations, for looking at ways of providing substitute care options, when these are required, because of the circumstances that are facing that child. Child welfare also has the responsibility, when circumstances require, of reuniting the family or, if family reunification cannot occur, to actually look at the issue of permanency and to provide a permanent plan for that child.

The foster care population, which has been noted as representing one segment of the child welfare range of services that are provided, is growing very rapidly. In fact, up until 1986, the foster care population was showing a significant decline. Since 1986, we have seen a significant increase in the number of children who are entering foster care, and there are approximately 360,000 children who are currently involved in a foster care program.

I would characterize this particular group in the following way: First, these children are becoming increasingly younger; and, second, we are seeing them remain in care for a longer period of time. In 1985, the average median stay in foster care was 9 months; as of 1990, the median stay in foster care is closer to 5 years.

The third point I would make is that a disproportionate number of these children come from communities of color, and a disproportionate number of these children are also represented, unfortunately, by a low socioeconomic factor or poverty. So, those are the characteristics I think that we need to keep in mind, as we look at this very vulnerable population and this population at risk.

The surge in the numbers of drug-exposed children entering foster care has presented particular challenges for the child welfare system, and these challenges can be directly attributed to the fact that workers have large caseloads, workers are not prepared because of their training for managing the kinds of family situations that are presented in these families, and workers have access to inadequate resources.

As was noted, there is a scarcity of drug treatment resources which further complicates the ability of the child welfare system to respond to the needs of children affected by parental substance abuse. For example, the National Association of State Alcohol and Drug Abuse Directors found that, in 1990 alone, 280,000 pregnant women needed drug treatment, but less than 11 percent of this number actually received treatment. I might add that many of these programs that serve women often refuse to accept pregnant women into treatment.

The question is how do we go about the process of enhancing of strengthening the existing child welfare system, and to that end, the Child Welfare League would like to recommend that we explore ways of enhancing the continuum of care that is now made available for children, and that continuum should include family preservation programs. That continuum should also include family counseling programs, as well as, given the realities of the drug epidemic as we know it today, offer out-of-home placement and also services that can lead to a permanency plan for children.

We would also highly recommend the provision of specialized therapeutic child day care centers. Recently, in a New York Times Magazine article, Dr. Terry Brazelton, from Harvard University advocated strongly that we needed to create fragile child and family centers, recognizing that families are at risk and require a host of services in order to augment the kind of capacity that we need to build in these families.

We would also highly recommend the expansion of pre- and perinatal services, and would argue very strongly that services need to be coordinate and services need to be planned in a strategic way in order to address the epidemic that we are facing today.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF RICHARD L. JONES, PH.D.
CHILD WELFARE LEAGUE OF AMERICA

Good morning Mr. Chairman and members of the Panel. My name is Richard L. Jones and I am Executive Director of Boston Children's Service, a member agency of the Child Welfare League of America. I also serve as chairman of The Child Welfare League's Commission on Chemical Dependency and Child Welfare, a group of seventy experts from the fields of substance abuse and child welfare. On behalf of the Boston Children's Service, the Child Welfare League of America and the Chemical Dependency Commission, I thank you for the opportunity to testify before the Subcommittee on the impact of substance abuse on the child welfare system.

The Impact of Substance Abuse on Children

The integrity of family life and the well being of children have been profoundly effected by changes in American society in recent decades. Although some segments of American society have enjoyed an improved standard of living, many other groups have experienced fragmentation of family life, economic instability, poor housing or homelessness, and an inability to access basic health care. The same disparities apply to the use of alcohol and other drugs. Although the general population has moderated its consumption of alcohol and other drugs, surveys reveal that disadvantaged and minority communities are, as a group, engaging in an increased daily and/or chronic use of illicit drugs. Particularly troubling is the significant increase in the number of women of child bearing age who abuse drugs.

As parental alcohol and drug use has continued to rise, there has been an ever-growing increase in the number of infants exposed in-utero to various illicit drugs, infants and young children abandoned by their parents, and children who are subjected to abuse or neglect because of parental substance abuse. Infants and children are being referred to the child welfare system in unprecedented numbers. At the same time, there has been a dramatic increase in the number of children entering foster care, many of whom are substantially impaired as a result of parental alcohol and drug use.

The following statistics illustrate the immense problem that parental substance abuse poses:

* Cocaine, and its derivative crack, increasingly are being used by women. According to the 1988 Household Survey, 5 million women of child bearing age are current users of illegal drugs and at least one million women are reported to use cocaine.

* Drug abuse in pregnancy is becoming more prevalent. In a study of 11 hospitals in Pinellas County, Florida, 15.1% of white women and 14.1% of black women tested positive for drugs, regardless of socioeconomic status. Another survey of 36 hospitals conducted in 1988 found that on average, 11% of pregnant women used illicit drugs, the most common being cocaine.

* Pregnant drug abusers identified today are not typically teens, but instead are in their mid-twenties, and are likely to have one or more children in addition to the identified drug exposed newborn. Maternal alcohol and other drug use are affecting not only the infants born drug exposed but siblings who live in family environments in which alcohol and other drugs play a major role.

* As a result of maternal drug use, as many as 375,000 infants are born every year exposed to one or more illegal

substances, and as many as 100,000 infants may be exposed to cocaine in some form. It is widely acknowledged that drug-exposed infants are being undercounted.

* Unprecedented numbers of newborns are at risk of abandonment. Drug exposed infants and infants who test positive for HIV often remain in the hospital as boarder babies, medically cleared but with no place to go. A Child Welfare League of America one-day survey of five major United States cities discovered that 69% of babies boarding in the surveyed hospitals were born to chemically dependent mothers.

* Infants exposed to alcohol and other drugs tend to have complex problems: they are at higher risk of premature birth and low birth weight; are more likely to be effected by Sudden Infant Death Syndrome; tend to display extreme irritability, hypersensitivity to stimulation, excessive crying; have difficulty "bonding" with caregivers; manifest some degree of neurobehavioral deficit; and experience developmental delays. These infants are physically and developmentally fragile.

* The CDC estimates that by the end of 1991, there will be 10,000 to 20,000 children with HIV infection, most of whom will be born to mothers who are IV drug users or who are sexually involved with an IV drug user. These children are highly vulnerable to physical and developmental delay and require specialized care.

*At least 100,000 of the children in the Head Start program have a parent with an alcohol or drug problem.

*In spite of the qualified success of existing prevention efforts, nearly 2 million teens are regular users of illicit drugs. One third of all teens have problems related to alcohol.

*Alcohol and drug use may predispose youth to engage in other high risk behaviors, resulting in unintended pregnancies and the spread of sexually transmitted diseases.

*In one study, 100% of homeless and runaway youth in San Francisco reported polydrug use on a regular basis.

*An estimated 1.3 million teens run away or become homeless each year. Family alcohol or drug abuse is the primary reason for over 250,000 of these teens leaving home.

*As many as 40% of the older youth in the child welfare system have had prior juvenile justice contact, usually involving offenses related to alcohol or drug use.

*The costs of substance abuse to society are staggering. It has been estimated that the direct, indirect, and related costs total over $177 billion annually - or about $750 for every man, woman and child in America.

*Chronic use of drugs, especially crack, has been found to undermine an adult's ability to parent. Studies reveal that substance abusing mothers tend to be children of substance abusers themselves, were physically or sexually abused by their parents, suffer from personality disorders of varying degrees of severity, and lack interpersonal supports. Many also lack the basic necessities for living: adequate employment, income and housing.

The Impact of Substance Abuse on the Child Welfare System

Given these trends, it is not surprising to find that the child welfare system has been seriously affected by the devastating impact of parental substance abuse on children. The picture is a startling one:

* It is estimated that between 50 and 80 percent of all confirmed child abuse reports and almost three-quarter of child fatalities involve some degree of parental alcohol and/or other drug abuse. Infants and children from chemically involved families are at increased risk of abuse and neglect. Among abused and neglected children, infants are at particularly high risk. A 1989 Boston study found that 64 percent of all abuse and neglect cases involved parental drug abuse, but when the child was less than one year old, substance abuse was a factor in 89% of the cases.

* Alcohol and other drug use have become the predominant characteristic in child protective services caseloads in twenty-two states and the District of Columbia.

* The foster care population, after shrinking in numbers for years, has begun to grow significantly. Between 1986 and 1989, the number of children in foster care rose 29%. There are now approximately 360,000 children in foster care as compared to 262,000 in 1982. Drug exposed infants, toddlers, and preschoolers endangered by parental substance abuse are the fastest growing foster care population.

* The number of very young children in foster care is also growing. In 1980, only 19% of the children in foster care were under five years of age; today, approximately 50% of the children in foster care are under the age of 6. Parental drug involvement is believed to be a primary reason for the foster care placement of these very young children.

* Boarder babies are entering foster care in significant numbers. A survey of ten hospitals by the General Accounting Office found that of the 4000 drug exposed infants born at those facilities in 1987, an estimated 1200 were placed directly from the hospital into foster care.

* In Los Angeles County, the number of children in foster care because of parental drug abuse rose by 1100% between 1981 and 1987. In some communities, parental drug use has precipitated as much as a 3000% increase in drug related dependency petitions over the last five years.

* It is estimated that between 30% and 50% of all identified crack exposed babies enter foster care.

* Some experts estimate that up to 80% of drug exposed infants will be placed in foster care before they reach one year of age. Others suggest that half of the children of addicted women not in treatment programs will enter foster before they reach a year of age.

The escalating number of alcohol and other drug affected children has stressed an overwhelmed child welfare system. Parental substance abuse has made increasing demands on the child welfare system, but at a time when they are most needed, human and fiscal resources within the child welfare system have constricted rather than expanded. The system has been hard pressed to meet its mandate to protect children, preserve families to the maximum extent possible and, when removal is necessary, to reunite children with their families.

The demands on the child welfare system are best appreciated when one considers the system's numerous responsibilities. Child welfare must respond to allegations of abuse or neglect through child protective services; provide crisis services to families at risk of maltreatment or disruption; arrange for out-of-home care when it is in the best interest of the child; provide case management services for children and their families; attempt to reunite children in care with their families; and assure a permanent plan for the child when reunification is not possible. Resources have never been entirely adequate to fully meet these responsibilities but the child welfare system nevertheless managed to hold its own in protecting children and supporting families.

With the dramatic rise in parental substance abuse, however, the system, which was already strained, has reached the breaking point. The unprecedented increase in referrals and the complexity that parental substance abuse introduces into risk assessment and protection of children have placed greater demands on the child welfare system. Child protective service investigations now consume the vast proportion of the human and fiscal resources available to child welfare agencies, and there are few, if any, resources available for prevention, early intervention, and support services, the interventions which vulnerable children and families affected by substance abuse most need to avert a crisis.

Child welfare agencies have encountered numerous obstacles in their efforts to protect children in chemically involved families while simultaneously attempting to assist families in resolving alcohol and drug abuse problems. Many of these obstacles can be characterized as a "lack of": a lack of workers to handle referrals; a lack of training for child welfare professionals regarding substance abuse, addiction, and the impact of substance abuse on parental functioning; a lack of adequate resources to provide the early intervention and support services that alcohol and drug affected families need to ensure the health and well-being of their children; a lack of available, accessible drug treatment, particularly for pregnant and parenting women, the uninsured, and the indigent; a lack of judicial resources that facilitate sound decision-making regarding the needs of children affected by parental substance abuse and the needs of their parents; and a lack of available and appropriate placement options when a child must be removed from parental custody.

As a consequence of these factors, child welfare professionals have experienced frustration and demoralization in their efforts to effectively protect children in chemically dependent families while supporting and enhancing parental functioning. High caseloads have presented a formidable obstacle to early intervention in troubled families. Limited resources have meant that workers are able to address only the most urgent cases and cannot respond to family problems until they become an emergency. Prevention and early intervention, which clearly offer the greatest probability of success with chemically involved parents, simply cannot be provided because workers must attend to crisis situations in which children are in actual danger or at imminent risk of harm. Moreover, assessment of the risk to the child posed by parental substance abuse has been complicated by inadequate training and supervision and confusing interpretations of what "reasonable efforts" are required to avoid foster care placement of the child.

The child welfare system has been required to assess whether traditional child welfare assessments and interventions are effective with parents who are chemically involved. Workers attempting to provide family focused services are being challenged as never before by parents whose primary or sole interest is obtaining the next supply of drugs. These realities have served to heighten the risk to many vulnerable children, further accentuating the crisis in the child welfare system.

The Inadequacy of Drug Treatment Resources

Further complicating the ability of the child welfare system to respond to the needs of children affected by parental substance abuse and their families is the scarcity of drug treatment resources, particularly for pregnant and parenting women and the uninsured. The following statistics illustrate the scope of the problem:

*It has been estimated that there are 17.7 million adults with severe alcohol problems and 9.5 million drug users in this country. Only 617,000 people are currently in treatment. At least 70,000 people are on a waiting list for alcohol or drug abuse treatment, and of that number, about half have been on a waiting list for at least 30 days.

* Of the approximately 7000 treatment programs in the United States, less than a hundred are designed to meet the special needs of women with children. Despite the fact that experts estimate that roughly half of crack addicts are women, there are few treatment resources to serve them. Of those that serve women, critical ancillary services such as child care are rarely available.

* Many programs that serve women refuse to accept pregnant women into treatment. In New York City, for example, a survey of 78 drug treatment programs revealed that 54% excluded all pregnant women, 67% refused to accept pregnant women on Medicaid, and 87% excluded pregnant crack-addicted women on Medicaid.

* The National Association of State Alcohol and Drug Abuse Directors found that in 1990, 280,000 pregnant women needed drug treatment but less than 11% actually received treatment.

* Of the programs that do accept pregnant women for drug treatment, less than half coordinate or provide prenatal care.

* Residential treatment, believed by many experts to be one of the most appropriate treatment for addicted women, is rarely available and Medicaid does not cover such services.

The absence of alcohol and drug treatment resources has posed a substantial obstacle to child welfare agencies in their efforts to preserve and strengthen families and to reunite children in out-of-home care with their families. Culturally relevant community-based prevention programs for substance abuse are wholly inadequate. Permanency planning has become difficult, if not impossible, when there are no resources for alcohol and drug treatment which are appropriate for parents who recognize the need for treatment and are motivated to obtain the treatment they need.

Strengthening the Child Welfare System

There is an overwhelming need for strong federal policy that addresses the impact of substance abuse on children and families and the impact that parental substance abuse has had on the child welfare system. Outreach, prevention, and treatment services to children effected by parental substance abuse, services that are essential to meet the physical, mental and developmental needs of children, are sorely lacking. Comprehensive and coordinated alcohol and drug treatment for biological parents who are chemically involved, particularly pregnant and parenting women, are urgently needed. Likewise, foster parents, adoptive parents and relatives who care for children affected by substance abuse, individuals often overlooked in program design and implementation, also need ongoing supportive services to assist them in caring for children whose needs may be particularly great.

The child welfare system would be enhanced by the development of federal policy that addresses substance abuse in families through a comprehensive, community based array of multidisciplinary services. Such services must include outreach, prenatal health care, post-natal health care, drug treatment, case management, education, and infant-parent and social support services. To be effective, these programs must be intensive; comprehensive in the sense of "one-stop shopping" for the various services that families need; coordinated among health, social service, education, drug treatment, and income assistance services; and sensitive to the unique needs of women and children, including the need for residential care that permits children to accompany their mothers into treatment. These programs must be adequately funded through institutionalized funding mechanisms that will insure the continuity of such programs.

We are building a body of evidence, albeit anecdotal at this point, that child care and other family support services greatly improve the ability to serve substance abusing women and to intervene effectively at a critical point in a child's life. Specialized, therapeutic child day care and parent-child centers can detect and address developmental delays in the child and foster healthy parent-child attachment, minimizing the need for family disruption. Too often, lack of preventive or support services early on results in significantly higher human and financial costs later.

Special programs also must be established to assist the overburdened child welfare system as it struggles to cope with the increasing number of drug exposed children who are experiencing serious physical, mental and developmental problems. Programs are needed to recruit, train and support specialized foster homes to care for drug exposed children; to train child welfare professionals to effectively work with families effected by substance abuse and to plan appropriately for drug exposed children who enter the foster care system; and to provide greater access to high quality medical, mental health and developmental services for drug exposed children in foster care.

I thank the Subcommittee for the opportunity to discuss this very important issue with its members.

Acting Chairman DOWNEY. Thank you, Mr. Jones.

Ms. Lubinski.

STATEMENT OF CHRISTINE LUBINSKI, DIRECTOR FOR PUBLIC POLICY, NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

Ms. LUBINSKI. Thank you very much, Mr. Chairman.

The National Council on Alcoholism is the Nation's ninth largest voluntary health organization and the only one dedicated solely to reducing alcoholism and other drug addictions and related problems.

In May of 1989, NCADD organized the Coalition on Alcohol and Drug Dependent Women and Their Children, to increase access to quality treatment services for alcoholic and drug-dependent women, and to prevent alcohol and other drug-related birth defects. I speak today on behalf of NCADD and the coalition.

I have chosen to structure this testimony to address a number of the questions raised in the hearing announcement. A word about alcohol: Alcohol is the leading drug problem in America today, associated as it is with 105,000 deaths per year, and implicated in a variety of health and social problems, including homicides, spouse abuse, child abuse, and profound birth defects.

Alcohol use and dependence frequently accompanies the use of or addiction to illicit drugs, especially cocaine. Polydrug use and addiction has become the norm, rather than the exception. Treatment models developed for alcoholism have been found to be effective, when applied to other drugs of addiction. Because alcohol is clearly the Nation's most widely used drug, and because alcohol is so frequently the silent partner of other drug addiction, any effort to productively respond to the impact of substance abuse on the child welfare system must be cognizant of alcohol's very significant role.

I would also note that alcohol is an equal opportunity drug, not disproportionately used by any class or race of people, and it is not detectable on a drug screen.

Second, should families with substance abuse problems be treated differently from other families in the system? Yes and no. Alcoholism and drug addiction are chronic progressive illnesses, with serious implications for parenting abilities and family functioning. It is critical that child welfare personnel responding to families where addiction is present be able to respond to the special health and social service needs of these families, just as they would to families where another disability or handicap posed a risk to child development and well-being.

Because these illnesses are treatable and because there is substantial evidence that recovery from addiction can dramatically improve the quality of family life, identification of addiction in troubled families and referral to treatment should be an integral part of child welfare services.

No, the other side of the issue is the appropriateness of removing children from families solely because parental or other drug use or addiction has been identified. Parental alcoholism and drug addiction are not in themselves evidence of child abuse or neglect or unfitness to parent. We would argue strenuously that, even when addiction is present, child welfare officials should engage in a thorough investigation and evaluation of the family, to identify potential risks, just as they would in a home where addiction was not a primary problem.

Too often, a positive drug toxicology screen of a newborn has triggered automatic removal from a mother's care prior to a complete family assessment. The trauma to both child and parent associated with removing the child, in the absence of other evidence of unfitness to parent, is not necessarily in the best interests of the child, nor does it conform to either the spirit or the letter of the Federal child welfare statute's goals of family preservation.

Models which institutionalize linkages between child welfare and the alcoholism and drug treatment system are currently the exception, rather than the rule. In the majority of cases, treatment resources to meet the needs of alcoholic and drug-dependent women with young children simply do not exist.

There are very few treatment programs in the country that are able to provide any kind of child care assistance to dependent women whatsoever. We know that the treatment, health care, child welfare, and foster care systems are all besieged with families in need of comprehensive services, with no place to turn. There are successful treatment models for alcoholic and drug-dependent women. Until recently, however, there has been little evidence of either a Federal or State commitment to create these treatment programs or to institutionalize a funding mechanism to insure the availability of services to addicted women and their kids.

Even if child welfare agencies are willing to make a more concerted effort to identify and refer family members who are addicted, such a commitment will be meaningless, if community treatment resources are not available to meet the needs of the families they serve.

NCADD and our coalition support the enactment of legislation introduced by Representative Durbin, H.R. 1189, which would expand Medicaid reimbursement for community based residential treatment facilities serving pregnant addicted women and their children.

The availability of residential treatment services for pregnant women is vitally important to the efforts of the child welfare system to maintain children and their families. These women need a range of services, including prenatal care, addictions treatment, housing and employment assistance and child care. They need a drug-free environment and the support of other women in recovery to stay drug-free and rebuild their lives.

Under H.R. 1189, residential programs eligible for reimbursement would provide comprehensive services, including therapeutic child care and parenting skills training, and these services would remain available to women throughout pregnancy and up to 1 year post-partum. We believe the enactment of this proposal would serve to reduce family involvement with the child welfare system and provide a vital service to the families already involved, where alcoholism and drug addiction is a major cause of family dysfunction.

Should substance abuse be treated as a special issue in State laws which address child abuse and neglect? NCADD and our coalition oppose the criminal prosecution of women, solely because they use drugs or alcohol while pregnant. We also oppose a finding of child abuse and neglect solely on the basis of a positive drug toxicology of a newborn, or on the basis of a finding of parental addiction.

While addiction is a risk factor for child abuse and neglect, they no more determine child abuse and neglect than do other risk factors, like mental illness in parents or hyperactivity in children. Policies which seek to equate the presence of alcoholism and drug addiction in parents with child abuse and neglect in the family unfairly label all mothers and fathers with these illnesses as child abusers.

Furthermore, the equation of addiction with child abuse discourages alcohol and drug-involved parents from disclosing and seeking services, for fear in discovery. These illnesses are already stigmatized, accompanied by shame and denial. It is a terrible irony that policies which purport to hold the child's well-being as paramount will only serve to encourage addicted parents to conceal their drug problems, while addiction progresses at great cost to parent and children.

If legislative proposals associating any other illness or disease condition with child abuse and neglect were put forward, there would be a public outcry about unfairness and discrimination. But our national discomfort with alcoholism and drug addiction, fueled by the self-righteous morality of the so-called "war on drugs" creates a supportive environment for such proposals.

There is a chilling eagerness to criminalize drug use during pregnancy, even when there has never been a concerted effort to establish a system of treatment services for this population of mothers and children. We oppose punitive sanctions against pregnant women, including child protective services determinations of child abuse or neglect solely on the basis of drug use. We oppose State laws which seek to define child abuse and neglect solely on the basis of parental alcohol and drug use.

In our view, any action to remove a child or to terminate parental rights must be preceded by a thorough assessment, including the family's needs and strengths. We support the provision of additional financial resources for the strained child welfare system. It is especially important that services aimed at promoting family and child well-being are adequately funded. Funding should be made available to train child welfare personnel about addiction-related issues and to hire an addiction professional to be part of the child welfare team.

Federal leadership is necessary, if we are to develop a system of care responsive to the needs of child welfare professionals and the families they serve. Expanding Medicaid should be a component of the national response. The creation of a new Federal categorical grant program aimed at funding residential treatment services for women and their children is another vital and critical step.

It is important to note that, of the almost $11 billion appropriated for the war on drugs, a meager 29 percent of those dollars are available for prevention, education, and treatment. The current priorities in the war on drugs are ill-conceived and should be replaced with more humane and more successful public health approaches.

The role of alcohol should be acknowledged and addressed. We support significant increases in alcohol excise taxes. The additional revenues would be appropriately spent by increasing alcoholism and drug treatment capacity, as well as other services which enhance the health of families. Expansion of comprehensive treatment programs which meet the needs of parents and their children must become an important part of our collective efforts to nurture healthy families and to prevent child abuse and neglect.

Thank you very much.

[The prepared statement and an attachment follow:]

STATEMENT OF CHRISTINE LUBINSKI
NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

Thank you for offering the National Council on Alcoholism and Drug Dependence the opportunity to testify on the impact of alcohol and other drug problems on the child welfare system.

The National Council on Alcoholism and Drug Dependence is the nation's ninth largest voluntary health organization, and the only one dedicated solely to reducing the incidence and prevalence of alcoholism, other drug addictions and related problems. NCADD serves as an advocate for alcoholics, other drug dependent persons and their families and for the development of alcohol and other drug policies in the best interests of the public health. NCADD has strong links with community-based organizations through its 190 affiliates in 36 states.

In May, 1989, NCADD organized the Coalition on Alcohol and Drug Dependent Women and Their Children as part of our ongoing work to increase access to quality treatment services for alcoholic and drug dependent women and to prevent alcohol and other drug related birth defects. Our goal is to counteract the growing trend to punish rather than treat pregnant alcoholic and drug dependent women by developing a humane, public health response and to unite the various organizations which share a concern about the many dimensions of maternal and child health. Coalition members include organizations concerned about women's health care; legal issues; civil rights; child welfare; alcohol and drug problems; and maternal and child health.

I offer this testimony today on behalf of both NCADD and the Coalition on Alcohol and Drug Dependent Women and Their Children. In addition, I would like to note that I serve on the Child Welfare League of America's North American Commission on Chemical Dependency and Child Welfare.

I have chosen to structure this testimony to address a number of the questions raised in the announcement about this hearing.

Alcohol's Role in Substance Abuse in Families

There is little doubt that alcohol is the leading drug problem in America today, associated as it is with over 105,000 deaths per year and implicated in a variety of health and social problems including homicides, spouse abuse and child abuse. In addition to its individual contribution to violence and family disruption, alcohol use and dependence frequently accompanies the use of, or addiction to, illicit drugs, especially cocaine. Polydrug use and addiction has become the norm rather than the exception. It is neither necessary, nor is it common practice to offer a discrete kind or course of treatment, based on the drug of choice of the addicted person. Treatment models developed for alcoholism have been found to be effective when applied to other drugs of addiction. Because alcohol is clearly the nation's most widely used drug and because alcohol is so frequently the silent partner of other forms of drug addiction, any effort to productively respond to the impact of "substance abuse" on the child welfare system must be cognizant of alcohol's very significant role. Secondly, because alcohol is a legal drug, acknowledgement of the role of alcohol and the disease of alcoholism in triggering child welfare concerns serves to frame the issue in terms of public healthy and social service concerns, rather than in the context of a moralistic or law enforcement model.

Should families with substance abuse problems be treated differently from other families in the system?

The short answer to this question is yes and no. Yes. Alcoholism and other drug addictions are chronic, progressive illnesses with serious implications for parenting abilities and overall family functions. In this regard, it is critical that child welfare personnel responding to families where addiction is present be able to respond to the special health and social services needs of these families, just as they would to families where another disability or handicap posed a risk to child development and well-being. Because alcoholism and drug addiction are treatable illnesses and because there is substantial evidence that recovery from addiction can dramatically improve the quality of family life, identification of alcoholism and/or other drug addiction in troubled families and referral to appropriate treatment resources should be an integral part of child welfare services. When family preservation is a goal of a child welfare intervention, addressing the impact of addiction on family functioning is critical.

No. The other side of this issue is the appropriateness of removing children from families solely because parental alcohol or other drug use or addiction has been identified. From our perspective, such policies or actions are not appropriate. Parental alcoholism and other drug addictions are not in themselves evidence of child abuse or neglect or unfitness to parent. We would argue strenuously that even when alcoholism and drug addiction are present, child welfare officials should engage in a thorough investigation and evaluation of the family to identify potential risks to the child, just as they would in a home where addiction was not a primary problem.

Too often, a positive drug toxicology screen of a newborn has triggered automatic removal from a mother's care prior to a complete family assessment. The trauma to both child and parent associated with removing the child, in the absence of other evidence of unfitness to parent, is not necessarily in the best interests of the child nor does it conform to either the spirit or the letter of the federal child welfare statute's goals of facilitating healthy family functioning and family preservation.

To what extent are drug and alcohol treatment included among the child welfare services that states make available? How available is treatment for women? What do we know about the success of alternative treatment programs for various subclasses of substances?

Although there are a number of cooperative models in place which institutionalize linkages between the child welfare system and the alcoholism and drug treatment system, these models are currently the exception rather then the rule. In most cases, child welfare workers receive no substantive training about family alcoholism and drug addiction, nor are they necessarily aware of treatment resources in their community. Moreover, in the majority of cases, treatment resources to meet the needs of alcoholic and drug dependent women with young children simply do not exist. There are very few treatment programs in the nation that are able to provide any kind of child care assistance.

There are even fewer programs that serve pregnant addicted women. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) reports that the publicly funded treatment system in this nation is only able to serve about 11 percent of the 280,000 pregnant alcoholic and drug dependent women in need of treatment. A 1989 study by Wendy Chavkin, M.D., of 78 New York City drug treatment programs found that women claiming to be pregnant and addicted were refused service by 54 percent of programs, 67 percent denied treatment to pregnant addicts on Medicaid and 87 percent denied treatment to pregnant women on Medicaid addicted to crack. We know that the treatment, health care, child welfare and foster care systems are all besieged with families in need of comprehensive services and that they have no place to turn.

There are successful treatment models for pregnant alcoholic and drug dependent women and for addicted mothers with dependent children. Until recently however, there has been little evidence of either a federal or state commitment to create these treatment programs or to institutionalize a funding mechanism to insure the availability of services to addicted women and their children. Even if local and state child welfare agencies are willing to make a more concerted effort to identify and refer family members who are addicted to treatment services, such a commitment will be meaningless if community treatment resources are not available to meet the needs of the families they serve.

To facilitate the creation and enhancement of alcoholism and drug treatment to meet the needs of pregnant addicted women and their children, NCADD and its Coalition on Alcohol and Drug Dependent Women strongly support the enactment of legislation introduced by Representative Durbin --H.R. 1189 -- to expand Medicaid reimbursement for community-based residential treatment facilities serving pregnant addicted women and their children. The availability of residential treatment services for pregnant addicted women is vitally important to the efforts of child welfare personnel to maintain children in their families through assisting families in resolving their problems. Many pregnant addicted women need a range of services including prenatal care, addictions treatment, housing and employment assistance and childcare. Services are fragmented and it is very difficult for women with little or no money to take their children across town in order to get the care they need. Many of the pregnant women in need of services are addicted to more than one drug, have been addicted for a long period of time and are going to need long term rehabilitation before treatment will be successful. This type of treatment is not likely to be successful on an outpatient basis or through a limited 21-28 day residential stay. Studies indicate that treatment outcome improves in direct relation to the intensity and length of treatment provided. Finally, most of the women who will utilize residential services live in drug-infested neighborhoods. Their homes and communities are not safe. They need a drug free environment and the support of other women in recovery to stay drug free and rebuild their lives.

H.R. 1189 - The Medicaid Substance Abuse Treatment Act of 1991 - would give states the option of offering Medicaid-reimbursed residential drug and alcohol treatment services to eligible pregnant women and parents and their children. Residential programs eligible for Medicaid reimbursement must provide a comprehensive set of services including therapeutic childcare and parenting skills training and these services would remain available to women throughout pregnancy and up to one year post-partum. We believe the enactment of this proposal and the establishment of a system of comprehensive treatment services for pregnant addicted women and their children would ultimately serve to reduce family involvement with the child welfare system and would provide a vital service to the families already involved with the system where alcoholism and drug addiction is a major cause of family dysfunction.

To what extent should substance abuse be treated as a special issue in state laws which address child abuse and neglect and the termination of parental rights?

NCADD and the Coalition on Alcohol and Drug Dependent Women and Their Children oppose the criminal prosecution of women solely because they were pregnant when they used alcohol or other drugs. NCADD also opposes a finding of child abuse or neglect solely on the basis of a positive drug toxicology of a newborn or solely on the basis of a finding of parental addiction. We have grave concerns about amendments to a number of state laws identifying alcohol or other drug use during pregnancy as prima facie evidence of child abuse or neglect.

While alcohol and other drug use or addiction may clearly be risk factors for child abuse and neglect, they no more determine child abuse or neglect than do other risk factors like mental illness in parents or hyperactivity in children. Policies which seek to equate the presence of alcoholism and drug addiction in parents with the existence of child abuse and neglect in the family unfairly label all mothers and fathers with these illnesses as child abusers. Furthermore, the equation of addiction with child abuse discourages alcohol and drug involved parents from disclosing and seeking services for fear of discovery. Alcoholism and drug addiction are already stigmatized illnesses, accompanied by shame and denial. It is a terrible irony, that policies which purport to hold the child's well-being as paramount will only serve to encourage addicted parents to conceal their drug problems, while addiction progresses at great cost to parent and children.

For too long, alcoholic and drug dependent women had to make choices between seeking treatment services or keeping their children with them. With child care opportunities virtually non-existent in the treatment system, women without family resources frequently were forced to place their children in foster care while they underwent treatment. In a significant number of cases, the stigma associated with addiction made child welfare authorities hesitant to return children to a woman in early recovery, even though they had been voluntarily placed. Now in a number of states policy has been enacted which will discourage addicted women, especially pregnant addicts from ever coming forward for help. If legislative proposals associating any other illness or disease condition with child abuse and neglect were put forward, there would be a public outcry about unfairness and discrimination. But our national discomfort with alcoholism and drug addiction, fueled by the self-righteous morality of the so-called "war on drugs" creates a supportive environment for such proposals. There is a chilling eagerness to criminalize drug use during pregnancy, even when there has never been a concerted effort to establish a system of treatment services for this population of mothers and children.

We strongly oppose punitive sanctions against pregnant women who use alcohol and other drugs during pregnancy, including child protective services determinations of child abuse or neglect solely on the basis of drug use. We oppose state laws which seek to define child abuse or neglect solely on the basis of parental alcohol or drug use. We oppose any federal initiative which seeks to facilitate the enactment of such laws by states. In our view, any action to remove a child from a family or to terminate parental rights must be preceded by a thorough assessment of the family, including the family's needs and strengths and potential danger to the child. In addition, facilitating parental access to alcoholism and drug treatment should be a critical component of family preservation efforts.

Conclusion

There is little doubt that alcoholism and drug addiction has been a significant factor in state and local child welfare services. We support the provision of additional financial resources for the strained child welfare system. It is especially important that services aimed at promoting family and child well-being are adequately funded. Funding should be made available to train child welfare personnel about addiction-related issues, as well as to hire an addiction professional to be part of the child welfare professional team.

It is also clear, however, that coordination among a range of health and social service systems is necessary if families are to receive adequate services and child abuse and neglect are to be prevented. The availability of quality, comprehensive alcoholism and drug treatment services, especially services for pregnant women and other mothers with dependent children, is critical to the ability of the child welfare system to adequately respond to families where alcoholism and other drug addiction is present. Federal leadership is necessary if we are to develop a system of care responsive to the needs of child welfare professionals and the families they serve. The expansion of Medicaid to provide residential treatment services for pregnant women and their dependent children should be a component of the national response. The creation of a new categorical grant program explicitly aimed at funding model residential treatment services for women and their children is another critical step. Federal law which now requires that states spend ten percent of their federal Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant on new and expanded services for women should be carefully monitored for state compliance.

We are aware that these proposals are costly and that there is a need for fiscal restraint. However, it is important to note that of the almost $11 billion appropriated for the War on Drugs, a meager 29 percent of those dollars are available for prevention, education and treatment. The current priorities in the War on Drugs are ill-conceived and should be replaced with more humane and more successful public health approaches. The role of alcohol in the nation's drug problems should be explicitly acknowledged and addressed. NCADD supports significant increases in alcohol excise taxes. The additional revenues would be appropriately spent on increasing alcoholism and drug treatment capacity as well as other services which enhance the health of families. Significant expansion in comprehensive treatment programs which meet the needs of parents and their children must become an important part of our collective efforts to nurture healthy families and to prevent child abuse and neglect.

Coalition on Alcohol and Drug Dependent Women and Their Children

Coalition on Alcohol and Drug Dependent Women and Their Children

Statement of Purpose
Passed by Coalition on January 23, 1990

The Coalition on Alcohol and Drug Depdendent Women and Their Children is a group of national organizations concerned about the health and welfare of alcohol and drug dependent women and their families. Coalition members include organizations concerned about women's health care; legal issues; civil rights; child welfare; alcohol and drug problems; and maternal and child health.

Because pregnant drug dependent women have so often faced discrimination, barriers and penalties, the Coalition is concerned about the provision of health and other appropriate services to them and protection of their rights. Therefore, the Coalition is organized to enhance access to preventive and educational services, health care, prenatal care, and alcoholism and drug addictions treatment for women, and to ensure the availability of health and social services for their children. The Coalition believes that the interests of women and their children are best served through the health care and social service systems. Women should not be singled out for punitive measures based solely on their use of alcohol and other drugs during pregnancy.

NCADD
1511 K Street, N.W.
Washington, D.C. 20005
202-737-8122

Coalition on Alcohol and Drug Dependent Women and Their Children

ORGANIZATIONS SUPPORTING COALITION OPERATING PRINCIPLES

American Association for Counseling and Development
American Civil Liberties Union
American College of Nurse-Midwives
American Medical Students Association
American Nurses Association
American Public Health Association
American Society on Addiction Medicine
Association of Marriage & Family Therapists
Association of Maternal and Child Health Programs (AMCHP)
Center for Child Protection and Family Support
Center for Law and Social Policy
Center for Science in the Public Interest
Children of Alcoholics Foundation
Criminal Justice Policy Foundation, The
Legal Action Center
March of Dimes
National Abortion Rights Action League, NARAL
National Association for Children of Alcoholics (NACoA)
National Association of Alcoholism & Drug Abuse Counselors
National Council of Jewish Women
National Council on Alcoholism and Drug Dependence
National Family Planning and Reproductive Health Association
National Perinatal Association
National Society of Genetic Counselors
National Women's Health Network
National Women's Law Center
NOW Legal Defense and Education Fund
Southern Regional Project on Infant Mortality
Women's Legal Defense Fund

State Based Groups

Coalition of Addiction, Pregnancy and Parenting
Louisiana Coalition for Maternal and Child Health
Human Development Center of Pasco
Task Force for Chemically Dependent Women Seattle-King County

2/25/91

1511 K Street, N.W.
Washington, D.C. 20005
202-737-8122

Coalition on Alcohol and Drug Dependent Women and Their Children

Coalition on Alcohol and Drug Dependent Women and Their Children
Guiding Principles

The Executive Committee of the Coalition on Alcohol and Drug Dependent Women and Their Children has drafted nine principles to guide the Coalition's work. The principles are now being circulated to Coalition members for their endorsement. Ultimately, membership in the Coalition will be defined by a commitment to the principles. The principles are:

•The Coalition supports the expansion of culturally sensitive alcoholism and drug dependency treatment services appropriate for women and their families and opposes the discriminatory exclusion of pregnant and poor women from these services.

•The Coalition supports equal access to a continuum of comprehensive, family-centered health and social services for all children affected by alcoholism and drug dependence.

•The Coalition supports increased research efforts on the medical, psychological and social impact of alcohol and other drugs on women, children and families.

•The Coalition opposes the criminal prosecution of women solely because they were pregnant when they used alcohol or drugs.

•The Coalition opposes discrimination against women of color in the delivery of health and social services related to alcohol and other drug dependence and in the application of punitive measures based on alcohol or other drug usage during pregnancy.

•The Coalition supports equal access for all women and infants to high quality health care services including prenatal, postnatal and infant care.

•The Coalition supports increased prevention and education efforts for public and professional communities regarding alcohol and drug problems among women and the effects of these problems on pregnancy outcome and child development. Prevention programs which are gender-sensitive and meet the needs of underserved groups of women, including women of color and women with low literacy skills, are especially needed for girls and women of childbearing age.

•The Coalition supports the development and implementation of policies and social service programs which preserve family unity and promote family wellbeing.

•The Coalition opposes the imposition of mandatory drug testing of women and children and mandatory reporting requirements for health care professionals except for the purposes of collecting confidential epidemiological surveillance data and providing necessary treatment services.

Organizations are encouraged to utilize any or all of these principles in their local and state-based work relating to pregnant alcoholic and drug dependent women and their children. In the near future the Coalition intends to cultivate a local and state membership base in support of these principles. We would be pleased to have a large number of organizations endorse them and join the Coalition.

Organizations interested in receiving the complete version of the principles and accompanying rational for review and possible organizational adoption, can contact Peggy Stotz at the Coalition, c/o The National Council on Alcoholism and Drug Dependence (1511 K Street, N.W., Washington, DC, 20005, 202/737-8122).

Acting Chairman **Downey**. Thank you, Ms. Lubinski.

Ms. Kitchen, you mentioned that you receive a Federal grant to provide services to substance abusing families at risk of abandoning their children, and you serve 1 out of every 4?

Ms. **Kitchen**. In one hospital in Kansas City, so we are only serving a small portion of the population, yes.

Acting Chairman **Downey**. Just in that one hospital, what happens with the other 3 families?

Ms. **Kitchen**. At the public hospital, the social worker identifies and does a risk assessment tool much like the one that UCLA developed, and determines the amount of risk and then, if there is a high risk, then she will refer to the child protection agency and other services in the community.

What those families do not have that the children and families in our program have is the assurance of all the links working together carefully, but they do have the linkage coordinator working on their behalf, so they have some services, but not the comprehensive component.

Acting Chairman **Downey**. Ms. Lubinski, are any States doing a particularly good job, in your opinion, in the provision of substance abuse treatment services for pregnant women and women with children?

Ms. **Lubinski**. Probably the best services for women in general, and pregnant women in particular, currently do exist in the State of California. I must tell you that New York has a shameful record of providing treatment services to women in general, and with the crisis in perinatal addiction, are just beginning to provide some services to this population. But California and Massachusetts have long been the model for women and addiction services.

Acting Chairman **Downey**. But it is still inadequate?

Ms. **Lubinski**. It is still inadequate, yes.

Acting Chairman **Downey**. Grossly inadequate?

Ms. **Lubinski**. Grossly inadequate.

Acting Chairman **Downey**. And they are the best?

Ms. **Lubinski**. They are the best.

Acting Chairman **Downey**. Ms. Walker and Mr. Jones, I want you to help me for just one second. If I had 2 or 3 minutes to explain the problems in child welfare to a colleague on the way to a vote on child welfare, I would start off by saying that we have an enormous problem in this country in that we have too many poor children and too many children who are the products of parents who are using drugs and alcohol. I would continue by saying that the current child welfare and foster care systems are being overwhelmed and that the caseworkers have other responsibilities, like child protective services. All of the things that we know do work, and there are programs that work, are inadequately funded, because of other State problems. So we are in this terrible situation—we realize what the problem is and we now have 30 years of experience in dealing with it, but we just do not have the money, and this bill that we are going to introduce is going to try and provide the dough and the direction. Is that a fair summation of the problem? How would you correct it or critique it?

Ms. **Walker**. I think it is a fair summation of the problem. I think there are some additions that probably need to be made, and that is not only do we need more funding, but we also need to look at how current funding exists and how we might think about reorganizing that funding, in order to provide more appropriate services and better services.

Acting Chairman DOWNEY. That is a good critique.

Mr. JONES. I think the other aspect I would add is we really have to focus more on prevention. We have to look closer at what kinds of interventions are we really planning at not only the elementary school age level, but also trying to affect change in the medical profession in how they view alcoholism and how they view chemical dependency.

A lack of training that we really focus on with respect to the child welfare system is a problem that exists across most professions in the country today, and I want to highlight that, that the child welfare profession is symptomatic of an issue that really pervades the country today.

Acting Chairman DOWNEY. You mentioned Dr. Brazelton's clinics. Let's assume that Mr. McDermott and I want to steal that idea and call it the Downey-McDermott clinics, so they have our names. What would these clinics do, precisely?

Mr. JONES. The critical elements that Dr. Brazelton was presenting and also that most of us would support is the fact that many drug treatment programs do not encompass, one, a child care component, so we can keep mother and child together; and, second, we need to look at what are the linkages that can be leveraged with other services in the community. As was noted in an earlier presentation, oftentimes there are services available, but there is no way of accessing those, and the system becomes so complicated that a parent cannot take advantage of what does exist.

Third, we are talking about intensive work with the family, so rather than working with a caseload of 1 to 15 or 1 to 20, we are talking about a social worker being assigned to work with 1 to 5, and I think that makes far more sense, based on the outcomes that we can generalize from some of the early family preservation programs that exist around the country today.

The other major component, I think, really speaks to how we look at employment opportunities, how we look at job development, how we look at economic development opportunities for our communities.

The question was raised earlier about repeater pregnancies, and I think we have to acknowledge the fact that, too often in the lives of these women, there are not enough opportunities for developing their potential in other areas. Many of us feel that the drug situation is an attempt to almost self-medicate one's self, because there being so few opportunities available in one's own life or in one's own community.

Acting Chairman DOWNEY. Self-medicate one's self—is that a fancy term for "release from other problems?"

Mr. JONES. It probably would suggest more that many of these young parents are clinically depressed and, as a result of the depression, they are turning to alcoholism and chemical dependency as a way out.

Acting Chairman DOWNEY. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

This panel overwhelms me with questions that I would like to ask or put in the record. Let me clarify the question of the treatment programs for pregnant addicted women, whether it is alcohol or substance abuse. To what extent do you see it as having to be inpatient and what extent should it be outpatient, and how long should an inpatient program be and that sort of thing, to make clinical sense? Never mind the kinds of administrative steps that we get into, but from the positions that you operate, I would be interested in your ideas. If you were going to design the perfect program, you would have a program that was available to a woman who was picked up in pregnancy and found to be addicted, you would give her how long in an inpatient setting and how long in an outpatient setting?

Ms. LUBINSKI. I will give that a stab. I would like to see a residential treatment program available for any point during pregnancy, up to a year post-partum, which really gives the woman an opportunity to get on her feet, to bond with her child in a supportive environment, to get out of a drug-infested neighborhood, to begin some activity at vocational training and the like.

It would appear, because of the multiple issues, that pregnant addicted women face, medical management, prenatal care, that the optimal setting, and particulary since so many of these women have other dependent children, would be a residential treatment setting.

Now, I think, realistically, we are never going to have that kind of system set up. However, I think it is important to at least have some presence of residential care for pregnant women with dependent children in every State of the Nation, and we do not even have that right now, but that I think is probably the optimal treatment model for pregnant drug-addicted women with dependent children, would be residential long term.

Mr. JONES. I would just like to contrast that with the present-day realities, and the facts are that women, especially women who rely on public assistance and who are fortunate enough to find a treatment program, probably spend less than 6 weeks in a treatment program.

Mr. MCDERMOTT. That is an outpatient treatment program?

Mr. JONES. Outpatient or inpatient, also. Inpatient tends to be less than 6 weeks, and I think——

Mr. MCDERMOTT. Generally, a detox period, just to clean them——

Mr. JONES. Right. In order for treatment to work, I think Chris is absolutely right, that treatment is required for a longer period of time. And when you look at women who are not reliant upon public assistance or people who have other resources, those programs offer long-term treatment and the intervention tends to be far more effective because of the time factor.

Ms. WALKER. I would just like to add a point to that. I think it is difficult to say that there should be one type, because I think our experience shows that we not only need the residential treatment programs, but we also need the after-care programs, and this is often what happens, in terms of a person who does have the opportunity to have the residential treatment. Women particularly come home and find themselves in the same stressful situations, with the child caring responsibility, family caring responsibilities, jobs, housing, et cetera, and they revert back, so we also need to think about residential treatment centers that make some sense, but also we need to think about after-care support for a population that is very vulnerable.

Mr. McDermott. I am very aware of the therapeutic day care kind of model and the effectiveness of it. It is a question of what has to precede this that I was really grasping for.

Ms. Kitchen. I would just add a point that if you are starting at the child welfare system level, you need to have caseworkers that are knowledgeable of the drug and alcohol resources and will refer for assessment to those centers to get good plans.

In our community, we have a prenatal and post-partum drug and alcohol treatment center where children can go. It is working, they are delivering, they do go to medical followup, you do need the counseling, and the after-care support. I do not think you can do a 30-day wonder. I think you need to have open-ended flexibility and drug-free environments for them to go home after they have been on that long road to recovery.

Mr. McDermott. Sometimes, when you get to the end of the panel and to the last person, they say something that some of the rest of you did not comment on. I would like to hear you talk, because I found it particularly difficult, the whole business about whether or not you decide that somebody who is using drugs is a bad parent on the face of it.

I have personal experience, being an expert witness in cases where I got in trouble with welfare workers who were trying to deprive a woman of her kids, but had never provided any kind of treatment for her, although they diagnosed her as a drug-addicted person and all the rest, and 6 months and a year and 18 months later they came along and said, yes, she should be deprived of her children, having given her nothing in that period to help her, and I said I did not think that was quite a fair test of her capability to be a mother, if you recognized a problem but did not deal with it.

So, I would like to hear the rest of you comment on Ms. Lubinski's comments about whether or not somebody is per se a bad parent, because they used drugs or alcohol.

Ms. Walker. On the face of it, I would certainly say no, that person is not a bad parent if they used drugs or alcohol. It depends on how that impacts on the child. Now, certainly, the person is responsible, but the issue is whether they are neglecting or abusing their child. I think the law would say that you cannot say that a parent's child should be removed if the parent is using drugs or alcohol, there has to be some impact on the child in terms of abuse and neglect.

Mr. Jones. In Boston, we have observed parents who have abused or are abusing alcohol, who are chemically dependent, and who are still very capable of parenting their children. I think the issue is how we really develop protocols that can help us assess the degree of risk that is facing that child. Within the Child Welfare League of America, also within the National Commission on Chemical Dependency and Child Welfare, we are trying to find ways of formulating risk and assessment protocols, so we can get to that very question.

I do not think that question has been answered as objectively as we possibly can. We are still struggling with it. I think we would all agree that, on the basis of the positive toxicology, that does not serve as the basis for removing a child. There are other factors involved.

Mr. McDermott. What should a positive toxicology trigger? I think if a woman delivers a baby or if she goes in for prenatal care and she has a drug test and it is positive, what should happen? Since we are talking ideals here, we might as well talk about what we would like to have.

Mr. Jones. A red light should go on immediately, we should move in with a cadre of services——

Mr. McDermott. CPS?

Mr. Jones. CPS is one facet, but I think the other services should be focused on the parent, as well as the child. We need to look at treatment, to get her into a detox program as quickly as we possibly can, we need to look at and plan for after-care, we need to plan for child care. There is an array of services that have to, I think, accompany the intervention around this example that you are citing.

Mr. McDermott. If she has a child already and this is her second child, would you take away the first child?

Mr. Jones. Keep in mind that, in foster care, the longer they are in foster care, the greater the risk of being moved from one home to another, so that we have to compare the trauma of disrupting the bond between that child and his or her family and frequent placements in multiple foster homes, and that is an issue I would raise. There are no easy answers, but we have to raise the tough questions.

Mr. McDermott. Would the rest of you agree with that, if somebody came up with a positive drug screen, you would immediately set in motion a series of evaluations?

Ms. Walker. Yes, a series of evaluations from a variety of perspectives, mental health, social services, and social services would not just be related to CPS kinds of issues, but social services broadly, in providing her with some immediate services to determine what her needs are.

Mr. McDermott. But would agree with Ms. Lubinski that that should not be a reason to immediately deprive the mother or have the child removed from the mother's care?

Ms. Walker. Right.

Ms. Lubinski. I guess I would be cautious about bringing CPS in on the first round, if there was not some other significant evidence of potential unfit to parent. I think the medical intervention is what is first needed.

We have to keep in mind that a drug toxicology does not even indicate we have a drug addict, it does not indicate we have an infant that is profoundly damaged, and I think it is important that we not think about these children as being profoundly damaged, because the evidence is still out, and I think it is a disservice to them to talk about them as if they will not fulfill their potential.

If we had hospital and medical personnel educated about alcoholism and addiction, we could have a complete evaluation of what kind of drug problem exists. We might have somebody who has gotten some misinformation about using a drug to trigger labor, but did not use drugs during their pregnancy. So, even a referral to treatment is not even necessarily appropriate. We need that kind of level of evaluation prior to immediately triggering a CPS report.

Ms. KITCHEN. I would say that, in our situation, a positive drug screen does trigger an assessment. The assessment tool that we use from UCLA is fairly sophisticated. It points out the degree or initial reading on where the focus should be, it helps develop a discharge plan, and to go from there.

I would say that a majority of them, based on that sophisticated assessment tool, do show that services need to be rendered and many do indicate opening a child protection investigation.

Mr. McDERMOTT. Thank you. I would only close by saying that I saw a case in the Seattle newspapers the other day, that you may or may not have seen, where a young waiter and waitress were fired from their job because they were counseling a woman who was obviously pregnant that she really should not be drinking alcohol, and they were persistent enough that they wound up out on the street, so there is a whole lot of levels to this whole issue, and I think you are to be commended for your testimony today.

Thank you.

Acting Chairman DOWNEY. I want to ask just one question in followup to those of Dr. McDermott. What happens in an upper-middle-income suburban hospital, do we do screening of those parents to determine whether or not they are alcohol or drug abusers, as well? Is that part of our regular hospital routine?

Mr. JONES. I think that one of the major findings from a number of studies, there is one in Florida, is that oftentimes women from upper- and middle-income families are not reported to CPS workers or to the child welfare workers.

Acting Chairman DOWNEY. Forgive me, with my two children, I am trying to remember if they did tests. Do they do blood tests of mothers? I showed up 15 minutes before my first child was born. We had to get the doctor in the labor room, and that was our big problem. They did not do any testing then.

Mr. JONES. There is not a consistent pattern across the country. It is very uneven.

Acting Chairman DOWNEY. So, it is conceivable that we have drug-abusing, alcohol-abusing parents in other neighborhoods and we do not know anything about them?

Mr. JONES. Correct.

Ms. LUBINSKI. I just want to say that there are States that mandate that every child be tested, but in States that do not do that, and there are very few of them, in many cases virtually all the testing is done in public hospitals.

One of our concerns about testing, which I neglected to really articulate, is the disproportionate kind of testing and referral of people—I mean there are hospitals that are reporting people because people are poor, because people do not have a fixed address. If you are AFDC, you get tested, if you are not, you do not. It is the abuse of that kind of testing procedure and its use for punitive purposes that we are really concerned about.

Acting Chairman **Downey**. My last question to you is that, in the last 2 years, has this problem of drug and alcohol abuse gotten worse, in your opinion, Ms. Kitchen?

Ms. **Kitchen**. Yes, I think it is significantly worse. We are more attentive to it, so it is possible that by looking at it more closely, we are seeing it more frequently, but that was why we formed our task force. We were not sure it was a problem, and, after looking at it more closely, we found that many people said yes, it is a problem, we are glad somebody is paying attention. We are grateful that you at the Federal level are looking at it seriously.

Acting Chairman **Downey**. Worse, Ms. Walker?

Ms. **Walker**. Worse.

Acting Chairman **Downey**. Much worse?

Ms. **Walker**. Yes.

Acting Chairman **Downey**. I do not want to put words in your mouth. Is it worse, or much worse?

Ms. **Walker**. Much worse.

Acting Chairman **Downey**. Mr. Jones.

Mr. **Jones**. I think not only is it much worse, but I think we have to recognize the fact that it is now in certain communities being accompanied by violence, and we are seeing evidence of that in all of our major urban centers across the country today.

Acting Chairman **Downey**. Ms. Lubinski.

Ms. **Lubinski**. I think it is worse, although I think it is important to note that there is a lot we did not see in the past. There continues to be no diagnostic tests for alcohol-related birth defects, unless you are talking about the full-blown fetal alcohol syndrome. So, there is a lot of drug exposure during pregnancy that we never detected and still are not detecting.

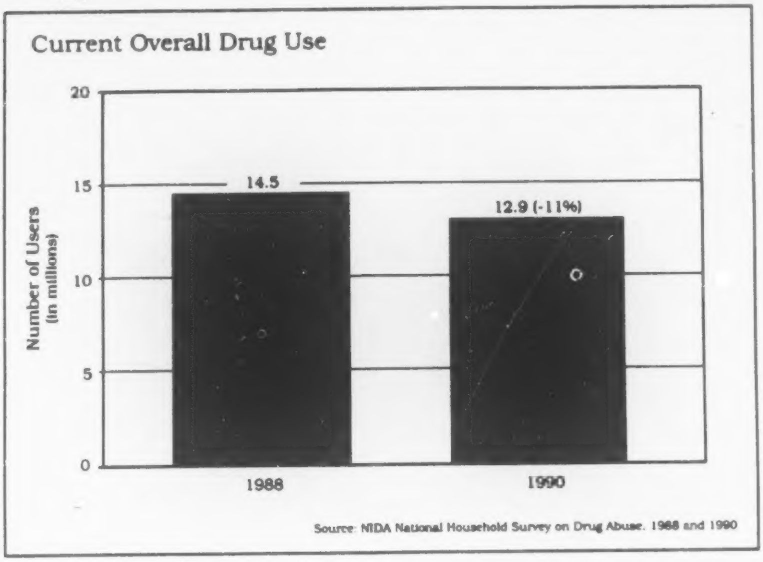
Acting Chairman **Downey**. Thank you.

You are all excellent and you give me hope that there are people out there who actually know what to do, and now we have to provide you with some of the electricity, so we can get your thousand points of light really shining bright. [Laughter.]

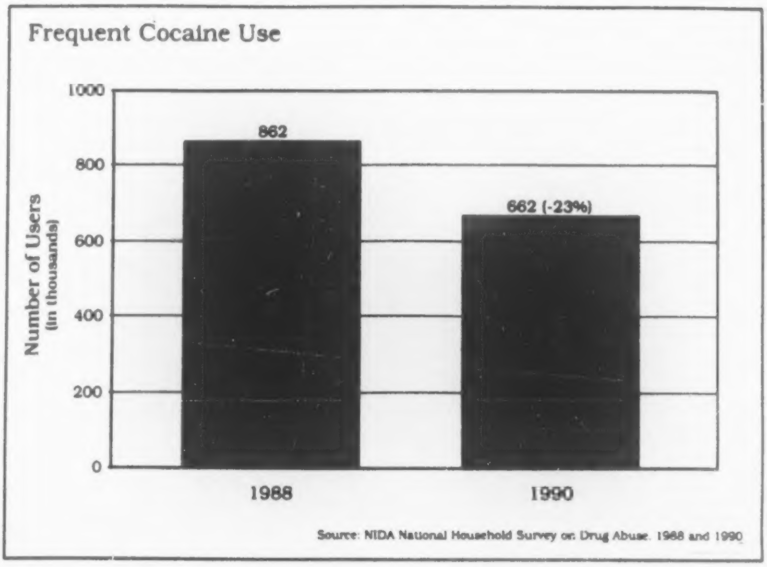
Thank you all very much. The subcommittee now stands adjourned.

[Whereupon, at 12:40 p.m., the hearing adjourned.]

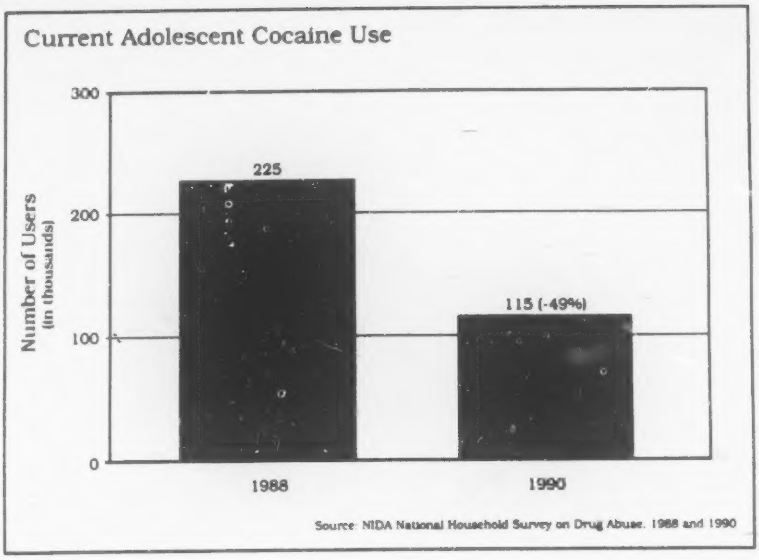
(By subsequent unanimous consent, Mr. Grandy submitted the following charts:)



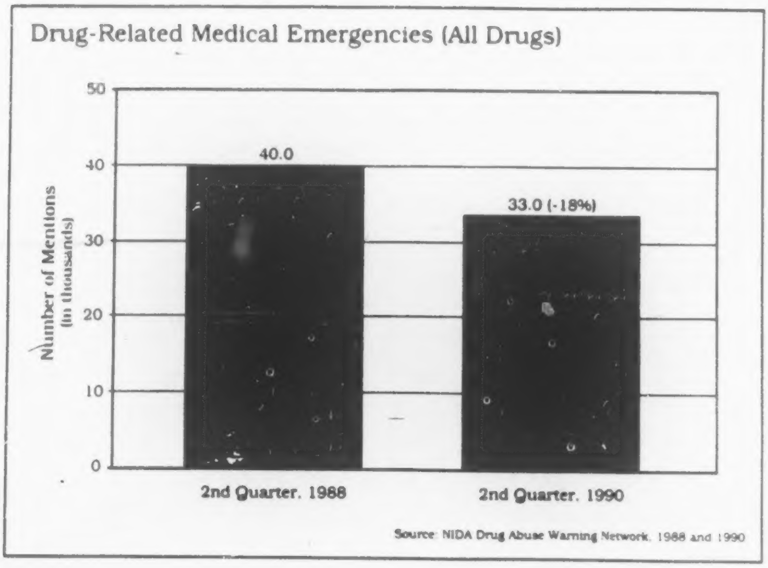
Source: NIDA National Household Survey on Drug Abuse, 1988 and 1990



Source: NIDA National Household Survey on Drug Abuse, 1988 and 1990

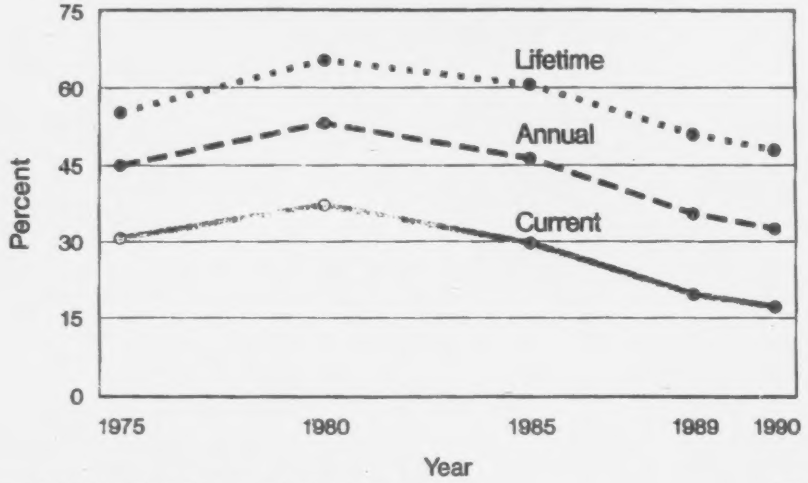


Source: NIDA National Household Survey on Drug Abuse, 1988 and 1990



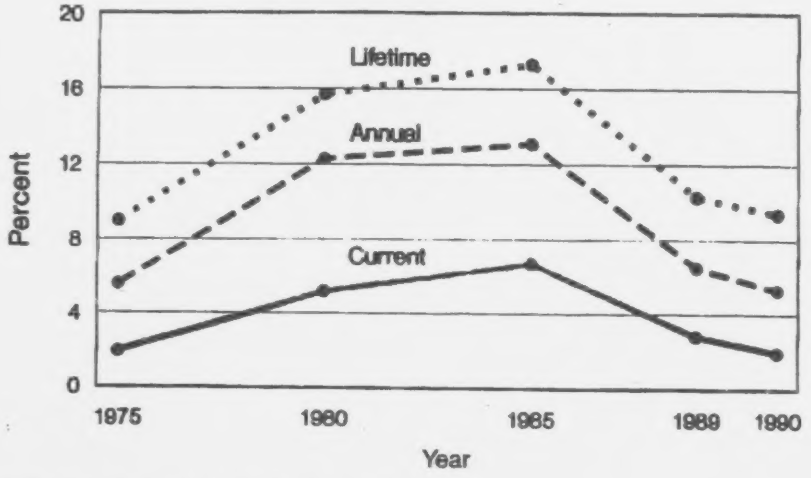
Source: NIDA Drug Abuse Warning Network, 1988 and 1990

Any Illicit Drug Use



Source: National Institute on Drug Abuse, Monitoring the Future, 1990 MB117-B

Cocaine Use



Source: National Institute on Drug Abuse, Monitoring the Future, 1990 MB117-A

**Broward General
Medical Center**

1600 S. Andrews Avenue, Ft. Lauderdale, FL 33316 • (305) 355-4400 • FAX (305) 355-5755

The Honorable E.Clay Shaw
House of Representatives

Dear Sir,

I appreciate this opportunity to respond to the Ways and Means Committee Hearing on the impact of substance abuse in the child welfare system. The children and families that are impacted by substance abuse need help that is in very short supply, not because the effort is not being made, but because the help that is available is fragmented. The programs that are needed for these families must provide help on the front end, not punitive response after a child is born to an addicted mother. The most effective program in Broward County allows for the withdrawal therapy of the mother while she is still pregnant, what it lacks is the ability to take the mother back in after the delivery of the baby. She is still in the recovering stages but she cannot return to the support of the rehabilitation clinic, social services helps to make arrangements for her to have an apartment but all to often it is within the environment that fosters drug abuse which she is trying to leave.

A comprehensive program which would allow all the agency's to work in concert is what is needed. Dade County currently has working in coordination the hospitals which report drug positive mothers and infants, the HRS Intake workers who make the initial evaluation of the family situation, the Protective Services workers who pick up the cases after intake, and the Public Health Nurses who follow the infants in the home. This kind of system prevents the loss of a family to follow-up because the whole system is aware of the case and is able to track them as they move around. There have been instances in which a repeat mother who has not kicked her habit has had a second or third child and because the system is fragmented the worker was not aware of the previous removal of a child from the home and allows the new baby to be discharged to the mother and the abusive environment.

As with most problems, intervention on the front end will prove to be most effective for the family and the most cost-effective for the system. A treatment program that would provide for therapy for the addict before and/or during pregnancy, that would allow her to return there after delivery and that would go the next step into providing a return to the community that is away from the environment that fostered the abuse in the first place. One suggestion is a cooperative apartment that would allow several recovering addicts to live together as a support group, that would help with child-care while they were learning skills to enable them to be productive and self-supporting and then gradually require less and less support until they were self-sufficient and able to provide for themselves and their children.

The families of substance abuse need help that other families do not in that a family without a home needs shelter, a family without food needs a meal, but a family with a substance abusing member needs a safe home, and drug treatment for the abuser that continues until the reasons for the drug addiction are gone.

Substance abusing families are very dysfunctional. The children who grow up in these homes don't have chance to learn appropriate parenting skills because their parents are unable to parent them. The child doesn't know from one moment to the next what the response from the parent is going to be, calm or erratic because they are high.

If the answer to this problem is not found and found soon an entire generation of children is going to be lost, they will have no opportunity to learn how to be productive members of our country and they will perpetuate the addictive cycle.

Respectfully,

Mary Patricia (Trish) Brant
Advance Registered Nurse Practitioner

6850 N.W. 14th Street
Margate, Florida 33063
April 20, 1991
355-5866

Congressman E. Clay Shaw
Broward Federal Building
299 E. Broward Boulevard
Fort Lauderdale, FL 33301

Dear Congressman Shaw:

This letter is written in an attempt to resolve the serious problems concerning drug addicted mothers. It is my belief that the mother must be part of the primary team when dealing in drug prevention. For this reason it is imperative to treat the drug addicted mother in a manner which would encourage a healthy family environment and one that is drug free.

As a social worker at Broward General Medical Center NICU mothers would often plead in desperation wanting to keep their babies while seeking refuge to fight their addiction. Presently, in Florida their are no long term drug programs available for treating the drug addicted mother without separating the mother from the baby and other children.

Modal PLan:

I would like to propose that we create a drug free environment to be built in a secluded area which can be secured from outside influences. The buildings could be designed similar to that of a college campus with a building for administration, and separate buildings which would provide for workshops, educational classes and dormatories for housing these mothers and their children. A full time day care program would be available for babies and preschool children (staffed by mothers). School age children would attend local schools in the area. There would be a playground on the premises for the children (supervised by the mothers) and a recreation area for the mothers (promoting physical fitness)

I recommend that this program be a one year voluntary total commitment program for addicted mothers and their children. The goal of this project would be to develop an extensive drug rehabiliation program while producing a self supporting and self maintained drug rehabiliation program.

This program should include a complete skills training program, an educational program, a parenting program, a life management program and an intensive rehabiliation program.

All maintenance of buildings and dormatories would be the responsibility of its clients and must be maintained at all times. All chores including cooking, serving of meals, sewing, laundry, planting produce for food would be shared on a rotation basis by all clients in the program. Each of the chores would be done to promote a healthier atmosphere

My suggestions wold be as follows:

1. AFDC checks would be transferred over to the facility as care givers.

2. Contracts from large corporations would provide work to be generated within the complex.

3. Wholesale plant nursery run by the clients.

4. A thrift shop and handmade garment store run by the clients.

5. A gift shop which produces ceramic and hand crafted items

6. A reupholstering and refinishing furniture shop.

7. A Beauty shop.

All workshops and shops should operate as a skills management program and small businesses. The client would receive the opportunity of learning business management. These programs would be staffed and supervised by educators and counselors.

I propose that a percentage of funds be generated to provide for the support of mantaining the entire program including the staff required, and a percentage be placed in an account for the clients needs for personal supplies.

I recommend that all residents and staff undergo periodic and without prior notice drug screening tests to monitor the safety of the program. Visitors would be limited to families and significant others who were screened by the staff to prevent invasion of drugs. Families would then be encouraged to join in special activities run throughout the year.

The dining rooms would be decorated to resemble a fine restaurant with table linins and place settings designed by clients interested in restaurant management.

The facility would have a nondenominational church service and a chapel available for its clients open 24 hours a day.

Since it is the goal of this program to reinforce the prevention of drug use and to learn behaviors resulting in a healthier lifestyle after leaving the facility, preparation for returning back into the community must be carefully planned long before the year is ending. A plan of action with guidance must be worked out carefully with each client to assist with such things as employment, daycare, living arrangements and follow-up counseling including home visits. Clients would be encouraged to participate in Narcotics Anonymous or other self help support groups.

It is my contention that without a complete intensive rehabilitation program the drug addicted mother will continue abusing their bodies, abusing their children and continue to spread highly contagious venereal diseases along with the spread of Aids.

The goal of the program in summary is to develop an intensive drug rehabilitation program, to help foster a healthy relationship between the mother and her baby (and other children) while building a self confident individual who has learned the skills needed to develop a life with a goal towards success and one who has learned how to deal with her addiction in a positive manner.

I strongly feel jail is the worse possible place for anyone with an addiction, We need a program which will change destructive behaviors and that must be done gradually if it is going to work effectively. The cost of this program would have to be the reponsibliity of its clients and not a drain on society.

Respectfully,

Arlene J. Golden

Arlene J. Golden

Broward General Medical Center

1600 S. Andrews Avenue, Ft. Lauderdale, FL 33316 • (305) 355-4400 • FAX (305) 355-5755

My name is Esther M.D. March, B.S.H.,R.N., I am the Neonatal Discharge Planner and Parent Educator in the Newborn Intensive Care Unit at Broward General Medical Center. It is my professional opinion that the reason why the Broward County maternal cocaine referral and treatment system is not working appropriately is based on several observations.

The first observation is that the system only accepts referrals of mothers whose infant's urine test are positive for cocaine after the mother has given birth. The mothers who have a positive history of cocaine usage and the mothers who have a positive urine test for cocaine and her baby's urine test is negative, receive no treatment because the H.R.S. agency does not accept this as an appropriate referral. The law states that a mother with a positive history of drug usage during pregnancy should be investigated and referred to a treatment program.

The solution is that all high risk prenatal and postnatal mothers with a drug problem should be referred to the H.R.S. Referral Hotline. The H.R.S. caseworkers should accept these referrals and carry out the investigations.

My second observation is that the treatment center in Broward County that accepts the majority of referrals is the Broward Alcohol and Drug Rehabilitation Center (BARC). The concept of this program is just, but the program design does not meet the needs of the pregnant mothers who have a drug addiction. The program design does not allow the infant to stay on the premises. Therefore, the maternal/infant bond never occurs, and the skills that the mother requires to care for and cope with her infant are limited.

The solution is that the treatment program should be designed to care for pregnant mothers and their infants. These programs also need a daycare setting.

My third observation is that in-house treatment programs are always full. There are not enough open beds for treatment.

The solution; add more beds to existing programs such as BARC or develop new programs designed to treat the whole family.

My final observation: Early Education Intervention. Education programs should start at a pre-school age, and be designed to teach self-respect, self-reliance and to modify a person's personality that will prevent drug addiction.

Brian D. Udell, M.D.
Neonatology
Broward General Medical Center
1600 South Andrews Avenue NICU
Fort Lauderdale, FL 33316

My name is Brian D. Udell, M.D., and I have been the Director of Newborn Intensive Care and the Regional Perinatal Intensive Care Center at Broward General Medical Center for the past 9 years. As we have been watching substance-exposed infants and their families, it has become apparent that the substance abuser NEVER uses one harmful agent. The specific drug which is taken is only a factor of its relative availability, and so as cocaine use may diminish, alcohol and marijuana use will increase, and tobacco continues to be used. Recent studies have shown that alcohol use during early pregnancy, for example, may be much more devastating to later growth and development than once believed, so that it may cause a lifetime of diminished capabilities to the affected individual.

In our experience, the families who are involved with child welfare agencies all seem to have some degree of dysfunction which is heightened in the cases of substance abuse. It becomes much more difficult to access such individuals for services, and probably clogs up the system as a whole. For this reason I believe that these families do need special consideration and services in order to streamline the entire process and get correct services to all needy families.

It has been our experience that very few services are readily available, and that again, the substance-abusing person is less likely to seek remedies. There needs to be a much greater effort to recognize the needs that such families have, not only to make services available, but to DEMAND that the family undergo some sort of treatment in order to help the innocent victims of this situation - the children. Until now, most of these treatment facilities have been generated at the local level and by local needs, with very little State or Federal support. Knowledge of which treatment programs are effective can only come by providing alternative centers; some outpatient, some inpatient, some more directed for drugs (and cocaine seems to require very specific treatment), some directed to alcohol, and some directed to dysfunctional families for other reasons.

I believe that we should identify and classify all at-risk families whatever the etiology, and seek appropriate services to the diagnosed problem. The inability for a parent or family to adequately care for their children will only result in more dysfunctional people down the road. Our intervention and correct treatment is the only hope for improving the future, and the SPECIFIC CAUSE of the dysfunction is only one early factor in providing necessary services.

○